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ABSTRACT

This research report is a description and analysis of the development and status of the first year of operation of the Parent-Child Center (PCC) program within Project Head Start. The perspective of the report is national, individual centers being regarded as illustrative examples of the national program. Because of the early stage of development and complexity of PCC activities, little attention is focused on outcomes and impacts. The conclusions and recommendations offered in this report must be considered in the context of the evolutionary nature of PCC. Chapter titles include: Organizational Development of the Parent-Child Centers; The Physical Facilities; The Parent-Child Center Staff; The Families Served; Programs for Children; Programs for Parents and Other Family Members; Health Services; Social Services; and Cost Analysis. Six extensive appendixes, 45 tables, 12 graphs, four figures, and a bibliography are provided. A review and summary of the report is available as PS 004 526. (WY)

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A NATIONAL SURVEY
# of the
PARENT-CHILD CENTER PROGRAM

Prepared for

Project Head Start
Office of Child Development
Department of Health, Education, and Welfare

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The conclusions and recommendations in this report are those of the Contractor and do not necessarily reflect the views of any federal agency.

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In addition to our central staff, the work of this project was accomplished with the participation of field research associates who are identified in the Methodology chapter of the report. Narrative reports prepared by a number of our field research associates are presented in a special supplement to this report.

Several consultants were involved and they are identified in the text related to their very useful contributions.

The staff is deeply thankful for all the assistance and cooperation received. As usual, the faults of commission and omission rest with the project staff.

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SUMMARY

INTRODUCTION

The Parent-Child Center Program

The Parent-Child Center (PCC) program was developed in response to the increasing evidence that the prenatal period and infancy are crucial influences on a child's subsequent development. Financed by the Office of Economic Opportunity and administered by the Washington office of Project Head Start, the Parent-Child Center program is a pilot demonstration to deliver comprehensive services to low-income families with children under the age of three and to expectant mothers.

Among the objectives established for the PCC's are the following:

1. Overcoming deficits in health, intellectual, social, and emotional development and maximizing the child's inherent talents and potentialities;

2. Improving the skills, confidence, attitudes, and motivations of the parents as citizens;

3. Strengthening family organization and functioning by involving the youngest children, the parents, older children in the family, and relatives;

4. Encouraging a greater sense of community and neighborliness among the families served by the center;

5. Providing training and experience for both professionals and nonprofessionals who may then be employed in work with parents and children;

6. Serving as a locus for research and evaluation of progress toward the objectives stated above.[1]

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[1] Parent and Child Centers, OEO Pamphlet 6108-11, March 1969 (revision) Foreword and Introduction.

Thirty-six communities were awarded planning grants at the beginning of 1968. By December of 1969:

--Thirty-five operational grants had been awarded to 11 rural and 24 urban agencies in 28 states and the District of Columbia.

--Thirty-three grantees were operating programs at 58 sites, and had served a total of 2,426 families with 3,449 children under the age of three. Of these, 25 percent had already terminated their enrollment.

--A staff of 943 persons was involved, including a full-time group of 553 persons, 145 part-time employees, and 188 volunteers, and others whose services are contributed by other local agencies.

PCC's are located throughout the country in metropolitan areas and remote hamlets (from Alaska to Hawaii to Appalachia to New York City). All PCC's were awarded federal grants of $175,000 for the first year and a 20 percent local contribution was required.

This Report

The report is a description and analysis of the development and status of the PCC program. Its perspective is national, individual centers being regarded as illustrative examples of a national program. Because of the early stage of development of this complex and innovative program, relatively little attention is focused on program outcomes and impacts. Many conclusions and recommendations are offered, however, and should be considered in the context of the evolutionary nature of the program.

ORGANIZATION OF THE PROGRAM

Early Development

Many programs for the poor have had start-up difficulties, and the PCC is no exception. Some difficulties of this type may be unavoidable, especially when programs venture into new areas.

There are enormous differences in the 36 communities selected for the pilot programs. Development of PCC's was hampered by the lack of support services--particularly in rural areas--inadequate numbers of eligible families in some areas, lack of support by community action agencies and neighborhood centers, and by bureaucratic delays in large cities. Lack of adequate facilities was also endemic and the program got off to a slow and uneven start. By December 1969, two centers had been serving families for more than 17 months; on the other hand, one was not yet funded and another had employed staff but had not yet served families. On the average, the 35 centers had been serving families for 12.1 months by the end of 1969. Those centers that were able to serve families most quickly after funding were in rural areas, had the fewest layers of administrative structure, and had recruited families prior to submission of their proposals.

Most centers have Policy Advisory Committees (PAC) that are designed to be the major link between participating parents and the funding source. PAC's vary from active, involved, and powerful to inactive and relatively powerless. Vague and conflicting delegations of authority have caused conflicts between PAC's, neighborhood centers, and community action agencies.

National planning and administration of new programs such as the PCC need to be flexible, prepared to cope with difficulties, and realistic in establishing schedules and requirements. The main text of this report suggests specific approaches to decreasing start-up problems.

Facilities

Provision of satisfactory facilities for centers had been one of the most serious and endemic problems faced in the early development period. While some facilities are still not adequate, the fact that they exist at all and are reasonably decent is a tribute

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to the ingenuity and perseverance of the staffs. The development of multi-site centers is quite common in rural areas as an approach to serving a highly dispersed clientele. This has had, however, a number of attendant administrative problems. Improved procedures and funding for identifying, renovating, and, if necessary, constructing facilities are essential.

Staff

As anticipated, staffing patterns vary greatly from center to center. There was a ratio of one staff member to 2.4 families on the average but there were wide variations from this average. Reflecting closely the ethnic composition of the client families, 42 percent of the staff members are Black, seven percent Mexican-American, 36 percent other Caucasian, five percent American Indian, seven percent are of the other ethnic groups, and three percent were not reported.

One of the most important aspects of the program is that 452 residents of target areas, including parents and other relatives of enrolled children, have been provided with jobs in the centers. While the overall ratio for the program of professional to nonprofessional staff is one to four, the range is broad. Eight centers are staffed solely by nonprofessionals, with the exception of the administrators; at ten centers at least a third of the staff is professional.

Although many problems have been identified with the employment of nonprofessional aides, they seem to have gained notable benefits from their participation in the program. Most centers provide preservice training for nonprofessionals that varies widely in amount and quality. Nearly a third of the staff members working in the centers report that they have received no preservice training; this is partially because of the high rate of staff turnover (27 percent). In-service training is also varied in amount and quality.

The unevenness of the training, the amount of turnover, and the difficulty of providing training while running a program suggest the need for a training program outside the PCC itself.

At this point in the program's development, about half of the staff's time is reported to be devoted to direct services to families and children and the balance to reports, meetings, and administration. Children under three are the most frequent recipients of staff services in day-care, play groups, and infant-stimulation programs. Older children and parents also receive a large portion of the staff's time. The staff assists the latter groups principally in terms of helping to provide for such basic physical needs as food, shelter, clothes, and medical care.

Families Served

Though the 1818 families currently enrolled in the Parent-Child Centers are not a homogeneous group, nearly all are very poor. As a group they have the following characteristics:

--Fifty-nine percent are headed by a father.

--The average PCC family has 5.7 members, but 22 percent have more than eight members.

--The parents are generally young, with 21 percent of the mothers under the age of 21 when first recruited.

--The average family has 1.42 children under the age of three enrolled at the PCC; these children's average age was 19.4 months when first enrolled.

--The major ethnic groups account for all but seven percent of the PCC enrollment: eight percent are Mexican-American, 27 percent other Caucasians, 47 percent Negro, and 11 percent American Indian.

--For such young parents, many have a very low educational level: only 22 percent of both fathers and mothers have completed high school. Thirty-nine percent of fathers and 28 percent of mothers have eight or fewer years of education.

--Forty-two percent of all PCC families were on welfare at the time of intake.

--Of those families headed by men, 26 percent of the men were unemployed at the time of acceptance into the PCC.

--Nearly all of the 19 percent of the PCC families who own their own homes live in rural areas.

--Fourteen percent have no running water in the home.

--Though incomes were not reported with a degree of accuracy or completeness that allows for exact reporting, our field staff reports that the families enrolled are not just poor, they are in large part among the poorest families in America.

It is important to recognize the characteristics of groups of PCC families, but it is equally important to recognize how the families differ. Many, but not all, of the families in each location and each ethnic group are the truly "hard core, multiproblem, disorganized" families who traditionally consume the bulk of public social services. It is important that all not be lumped into one large group for which a single intervention strategy is developed.

On the other hand, the dominant demographic characteristics of the four major ethnic groups served make it crucial that programs recognize these widely differing types of PCC families. These characteristics include the following:

--Almost half of the PCC families are Black and the percentage is increasing as more of the urban centers enroll families; nearly all of the Black families enrolled in the PCC's live in urban areas. Most are headed by women who are generally very young. Though not actually well educated, they report many more years of education than do the other families in the PCC.

--Most Mexican-American and other Caucasian families live in rural areas, have two parents, both of whom are poorly educated. The fathers are apt to be employed intermittently at low-skilled jobs. Lack of acculturation describes many of the desperately poor rural Whites as well as it does the Mexican-Americans. The resources of the communities, the employment opportunities, and the housing conditions of both these groups are deplorable.

--Most American Indian families enrolled in the PCC live on a reservation or in a rural area. Most of the families are headed by fathers who were unemployed at the time of intake. The parents report more years of education than do any but the Black families in urban areas. Though very poor, the lack of current income is not as severe a problem as the lack of long-range opportunities for employment.

PCC's clearly have concentrated on helping the most destitute segment of the population. This fact is important when assessing programs and accomplishments.

PROGRAMS

Both the types of program components developed and their relative emphasis vary widely among centers. Four major program components have emerged. These include programs for children, programs and activities for parents and other family members, health and nutrition services, and social services.

Programs for Children

Thirty-three centers report serving 2,580 preschool children while one serves only parents and another does not yet provide any services. In summary,

1,195	children are provided a center program
700	children are visited only in their homes
181	children are provided day care at the centers
135	children are provided home day care
2,211	total children under four years of age
369	other preschool children are served in 34 play groups in 14 PCC's
2,580	preschool children served

PCC's provide services in the following ways:

16	provide home and center programs
6	Provide only home programs
11	provide only center programs
1	provides no children's program
1	has not yet initiated a children's program

Home-visiting programs are usually staffed by nonprofessionals who are supervised by a teacher or child development specialist. In keeping with current theories emphasizing the early need for cognitive stimulation, the aides visit the homes and provide some kind of educational programs for the focal children and instruct mothers in how to help their children. At some centers, the major purpose of the home visit is to provide counseling and referral services to families.

Most of the home-care programs employ PCC mothers to care for children of other PCC mothers who may be working or attending center activities. This plan has the advantage of providing some income for needy families.

Generally, the children in center-based programs receive more hours of contact than those in home-visiting programs. While a few centers provide five-day-a-week play groups for all focal children, most provide a morning or afternoon program two or three days a week. Center-based groups are usually staffed by a supervising teacher or child development specialist and one or more teacher aides, although some are staffed entirely by nonprofessionals.

The programs for children reflect a wide range of theories of child development. They vary greatly from very sensitive and complete programs to others that are inappropriate for the age of the children involved or are sometimes punitive. What is perhaps most interesting is that quite a number of programs do work with infants less than a year old and in some cases only a few months old. Some of these programs strive to help the baby achieve normal physical, emotional and intellectual development. Other programs tend to be garden-variety day-care or nursery programs which, while useful, are nothing new or special in themselves but are serving a new group of children. Further development of these center-based programs has been inhibited by lack of adequate facilities.

Programs for Parents

During the first year of operation, centers learned many ways of recruiting and gaining the attendance of parents in PCC activities, ways of holding their interest, and techniques for encouraging staff to support parent activities.

Among the activities frequently participated in by parents were child development classes provided by 49 percent of the centers and attended by about a third of the enrolled mothers. A total of 564 mothers and 51 fathers were attending these classes. Home economics and home management classes were attended by a total of almost 1800 mothers.

In addition to providing employment for 146 mothers of enrolled families, another 81 mothers are being trained to become child care workers for eventual placement outside the centers. Adult education classes were reported by 34 percent of the centers and had enrolled approximately 270 mothers and fathers. Other activities developed for parents have included job counseling, vocational rehabilitation, typing, and driver training.

While most activities were attended primarily by mothers, a significant number of fathers participated in aspects of the program generally compatible with the male role and image. The PCC approach is clearly one that seeks to involve the whole family, and significant strides in this direction have been made.

Health and Nutrition Services

Health Status Reports were returned for 44 percent of the children under the age of three. The height and weight of these children are within normal limits, but tend to be on the short and heavy sides of the normative curves. About half had received immunization for DPT and polio prior to enrollment and about a fourth had received smallpox and measles vaccines prior to PCC examination. No tests for tuberculosis were reported for 69 percent of the children. Fifteen cases of tuberculosis were found among those tested. No tests for anemia were reported for 53 percent of the children; however, about 20 percent of the children who were tested were reported to be anemic.

Of the 1,526 children for whom Health Status Reports were returned, 28 percent had one or more conditions that required treatment. Of the sample of referrals for treatment subsequent to the initial examination, the largest number of referrals were for respiratory ailments and acute infections, followed by diagnostic tests, accidents, skin disease, intestinal symptoms, and nutritional disturbances, including malnutrition. In short, the PCC children need a lot of health care.

While many Parent-Child Centers provided medical services for all family members, our reports of these services are very incomplete. Examinations were reported for 3,494 people or about 25 percent of the family members enrolled, but it is most likely that the actual number of examinations is far larger.

Although most of the centers utilized multiple sources for medical services, twelve used private sources predominantly, twelve used Neighborhood Service Program (NSP) resources, and twelve used other group health sources including universities, the U. S. Public Health Service, and group insurance plans such as Kaiser-Permanente. Those PCC's that utilized private sources reported examinations on 34 percent of family members enrolled, while NSP and other medical groups provided data on about 20 percent. Most of the centers using private resources were rural, employed a nurse, and did not have to wait for the NSP health facilities to be developed before health care could be delivered. Although the findings are not conclusive, there is a strong indication that more medical services were delivered when private sources were utilized. Families also were reported to be more satisfied with these private sources and more willing to utilize them.

A nurse may well be the most vital member of the PCC team. While most centers employed a nurse, ten did not. PCC nurses have provided staff education on health matters, developed health education and nutrition programs for children and parents, sought and coordinated resources in the community and screened children in the play groups. Centers without nurses did not develop a full range of health programs, including such areas as classes in prenatal care, family planning, safety, and emergency care of infants.

Nutrition has been a subject of concern in nearly all PCC's. Nutrition programs included teaching parents about adequate diet, providing food and meals at some centers, and, in one case, diagnosing the nutritional status of the children. Snacks have been provided by all but two of the centers serving children and 16 have provided one or more meals a day for children attending day-care or play groups at the center.

Because PCC families are so desperately in need of better health care (including improved diets), the PCC's face an enormous challenge in this area. While much good work is being done, their present health-related resources seem hardly adequate to overcome the long-standing deficits of these families and to help the infants get the right start.

Social Services

All but two of the Parent-Child Centers have established social service programs designed to meet the needs of PCC families in one or more problem areas: material, social, psychological, or community.

Most social services within the PCC's are provided by nonprofessional staff.

The 129 social service aides, together with the seven professionally trained supervisors, the five bachelor's degree social workers, and the two nondegree supervisors, comprise the largest group of staff assigned to any program within the Parent-Child Centers.

The majority of the services provided by the social service workers are those designed to meet the material or social needs of the families and case finding, referral to services, and transportation to those services. Important activities toward meeting material needs include assistance in finding more adequate housing and provision of emergency food and clothing. Meeting the social needs of the parents through a variety of center and home programs is also a significant effort of the social service staff. Many of these activities might more appropriately be classified as recreation, but nonetheless they meet the social needs of adults as well as children.

While most Parent-Child Centers refer families to counseling services outside the centers, five also provide considerable treatment within the centers. These counseling and psychotherapy services are staffed by both paid and volunteer professional staff members. One center has developed a walk-in clinic where emotionally disturbed adults may receive treatment.

The social service program generally reflects a warm feeling of genuine concern by the center staff for all family members. Also, in some cases, social services are part of a strategy that first seeks to help families with their basic needs and then attempts to work specifically with the young children.

PROGRAM OUTCOMES

Because of the broad scope of the Parent-Child Center programs, outcomes must be sought not only among the children enrolled, but among their siblings, their parents, other family members, the staff of the centers, and the institutions in the community served by the Parent-Child Centers.

Effects on the Child Under Three

As a measure of the development of the focal children, the Bayley Infant Development Scales, a broad gauged and well-standardized method of comparing the development of infant and toddlers, was administered to 109 infants in six Parent-Child Centers. Forty weeks later the scales were readministered to 79 of these children who were available for reexamination.

The sample was chosen from both rural and urban PCC's and from different parts of the country. About 55 percent of the children tested were boys. The sample included the three major ethnic groups served by the PCC's: 48 percent of the children were Black, 25 percent Anglo, and 27 percent Mexican-American. The boys, at the time of the initial test, were an average of 14 months, or on the average of about two and a half months older than the girls. The children ranged in age from two months to 26 months when initially tested.

On the initial examination these children scored, on the whole, considerably below the norms (100) for their age as shown in Table 33. There did not appear to be any systematic relationship between the test scores and ethnicity, the location of the center or the family income, though of course all were from low-income families. On the initial test, older children scored lower than younger ones.

Overall Pretest and Retest Scores

	N	Mean Pretest	Mean Retest	T Test of Difference
Mental Development Index	79	77.4	87.7	3.9*
Psychomotor Development Index	79	91.1	98.4	2.2**

* $p < .01$ **$p < .025$

As can be seen, on reexamination positive gains occurred in both mental and motor scores. Consistently higher scores were found in motor ability than in mental development, though the gains in the mental development scores are greater.

Because of the size and nature of the sample, a good part of these gains may be statistical artifacts--more apparent than real. A larger study would need to be undertaken before it could be determined whether most of the differences found are a result of a regression to the mean or are related to the impact of the Parent-Child Center program. A longitudinal study would be necessary to determine whether the gains are maintained over a period of time.

On the whole, girls scored higher than boys on both the initial and the follow-up examinations. In the initial tests, the older the child, the lower the scores with respect to the norms. This was not the case on the retest scores. Aside from a slight motor ability superiority among Black children, no ethnic differences were found in the test data. Children in the centers with the more structured children's programs achieved the largest gains in examination scores; those enrolled in the least structured programs achieved smaller gains.

Comparison with other samples of low-income infants indicate that the PCC children on the whole had lower mental development scores than were found in other groups of impoverished children. This would be consistent with the finding that many of the PCC families are among the most destitute and poorly nourished, and with the high rate of anemia found among the children tested.

Because of its usefulness in identifying the needs of individual children and of assessing program effects, it is recommended that independent developmental examinations of PCC children be conducted as a regular part of the program.

Early in the visits, many of the field observers reported that the children appeared lethargic and inactive compared with other children their ages. Our field staff most often reported on the improvement in the appearance of the children--they often appeared cleaner, neater, more relaxed, friendlier, and more sociable and self-confident on later visits than when first recruited to the program. At several centers, parents reported that they had better relations with their children, that, as one mother said, "Now that I understand more about two-year-olds, mine bugs me less."

To be sure, some of the reports of both parents and staff may be expressions of enthusiasm for the services of the center and for their work. It is to be expected that infants will increase both their mobility and their verbalization in the span of a year, so that such reports may be only an indication that nature has taken its course. Only more extensive observation or testing could provide definitive answers.

Effects on Families

Staff of the Parent-Child Centers reported a wide variety of changes among the parents. Chief among these were improvement of everyday behaviors: housekeeping standards improved, along with the mothers' personal grooming and dress. This latter was confirmed by many of our own field research associates. Increased sociability and community involvement were frequently reported by PCC staff. Six of our field associates reported that the directors had noticed improvements both in self-concept and aspiration level of the mothers. Five reported better relationships at home, but two others reported that the mothers' increased independence and self-confidence had produced family strife. Many centers have had notable success in increasing the availability of food and housing; others have helped parents increase their use of community resources, and nearly all have improved health care services.

Field research staff report that a number of centers have been able to increase the employment opportunities of adults outside of the Parent-Child Centers. These reports are confirmed by the Termination of Service Reports completed by the centers on each family for whom service had been discontinued. Since the programs have been operating such a short time, these reports do not yet fully reflect the impact of the program. Even though the 608 families terminated had been served an average of only 3.8 months, some outcomes are already apparent, particularly in the area of employment. While there was an increase of only one percent in the employment of fathers, there was a 13 percent increase in employment reported for the mothers. Presumably, longer participation in the PCC program will increase these effects further.

Effects on the Community

It is too early, and beyond the scope of this study, to assess impacts of this program on the communities in which PCC's function, but many centers have achieved high visibility in their communities. Some of these are in major cities where such visibility is difficult. In one large city, the PCC was apparently the first interdisciplinary program for children.

In four southern communities, the PCC is a public model of integration. Several have done outstanding jobs in coordinating resources and achieving cooperation between agencies that had never really worked together before. PCC's in six cities have had visible effects on the operations of traditional agencies--in bringing about changes in either the public school systems, well-baby clinics, or welfare departments; in the development of new community programs in nutrition and food distribution; and in the delivery of medical services.

One PCC got the price of school lunches reduced; another got a publicly supported adult literacy program established; still another got guard rails installed in a high-rise public housing project. Another PCC brought about a number of changes in the clinic policy and appearance of a medical school serving PCC children. This same PCC negotiated policy changes with both the telephone and gas companies to make them more humane in dealing with the problem of late payments. And several, in this short period, have established themselves as a first stop in a child-related crisis--much in the style of the settlement houses of an earlier time.

Those Parent-Child Centers that have not yet brought about a change in the communities served have at least demonstrated the shortage of services available to low-income families and their children.

COSTS

This study is necessarily one of inputs--not outcomes. It is too early to measure outcomes and benefits in a program concerned with long-term developments in children. Evaluating PCC costs, furthermore, is exceedingly difficult. The programs are complex and offer a wide variety of services. Many are as comprehensive as a total community action agency. The goals of the program are expressed in abstract and presently nonquantifiable terms, and the program is still in its earliest stages of development. Many centers have only become fully operational in the six months preceding this report; some have still not fully implemented service. Finally, cost data are fragmentary--less than 30 percent of the centers provided cost allocation information for analysis, and most do not have control of their own accounting procedures or cost data.

Future cost-benefit studies will need to recognize both the long-term nature of the hypothesized benefits and the fact that there are no comparable programs for studies of alternative systems. Centers differ so widely in the range and intensity of their services, in their goals and priorities, in the community resources on which they can draw, and in the kinds of families they are serving, that intra-program comparisons are also exceedingly difficult.

Cost data were returned by only ten of the centers for one quarterly period, and cannot be considered as representative of the whole program. Examination of data from these ten centers illustrates some of the striking differences between centers. For example, in terms of the percentage of their resources devoted to programs for children under three, these ten vary from a low of five percent to a high of 38 percent. Six of these centers expend less for child-related activities than for services to parents and other family members. As could be expected, travel costs are highest in rural centers; community development costs are highest in urban centers. All but two of these ten centers report relatively high overhead costs, the range being from less than 10 percent to 66 percent.

Based on an annualized cost of seven million dollars for the entire program, costs are running $3840 per family or $2710 per child under three years of age. The original uniform grants of $175,000 per center envisioned enrollments of 100 children under three (or 70 families at the actual PCC ratio of 1.4 children under three per family enrolled). The actual average of 53.5 families masks the wide dispersion of center enrollments as well as the differences in programs, services, goals, methods, clients, and settings. A numerical indicator of the range is the range of annual costs per family served--which vary from $1400 to $10,000.

We have devised a system which, if required of the centers, can produce data useful for present management decisions, both locally and nationally, as well as for future cost-benefit studies. While the present data are only illustrative, they already indicate areas and practices in which program improvements are desirable.

CONCLUSIONS AND RECOMMENDATIONS

The Parent-Child Center program is an attempt to overcome the formidable developmental difficulties confronting the infants and young children of desperately poor families in this country. It is a pilot effort dealing on a broad front in new ways with tough problems, many of which have never been solved before. Thus, the program has the two objectives of learning more about how to enhance the development of children while at the same time operating programs to achieve this very goal.

The PCC's have recruited many of the very poorest families in the communities they serve and, for the most part, have provided these families with a wide variety of services and opportunities. The achievement of most centers in delivering service has been considerable.

Certain factors, in addition to generally limited knowledge about how to help infants in deprived families, have inhibited the development of the program. One such factor is the lack of adequate supportive services in many of the PCC communities. Another is the great difficulty in obtaining satisfactory physical facilities for the program. A third factor is the conflicts and uncertainties caused by vague and inconsistent delegation of authority to local organizations involved with the program, particularly the PCC's Policy Advisory Committees, community action agencies, and Neighborhood Service Programs.

Another set of limitations has been imposed by the shortage of persons nationally and in the PCC program who are expert in the field of infant and early childhood development, especially as it pertains to youngsters of poor families. This shortage is reflected in the fact that the programs for the infants often receive least attention in centers and are often the least expertly operated. To some extent, however, it has been learned that programs for the most deprived families must start by dealing with the basic physical needs of the parents before the educational, social, and psychological needs of the children can be approached.

Considering these background factors and the early stage of the evolutionary process the program is now in, the following conclusions and recommendations are offered.

1. This small, pilot program seems unnecessarily burdened with administrative structures and requirements. Greatly simplified organizational arrangements and administrative procedures would permit more time to be devoted to service activities.

2. Now that many of the difficult start-up problems have been overcome it should be possible to place greater emphasis on operating the program as a demonstration. This involves greater emphasis on data collection and reporting; isolation of specific issues for analysis; and more careful and systematic identification of program impacts on children, parents, and institutions. These steps would enhance policy makers' ability to plan new centers with a better understanding of the results of this demonstration.

3. Centers have performed well considering the small amount of guidance they have had on administrative or substantive matters. They have also developed in considerable variety. It is appropriate now, however, using what has been learned from the PCC experience and other programs, to develop some comprehensive guidelines. These guidelines for infant development in physical, cognitive, and social areas and for family development could be useful for program design, training, and technical assistance to operations.

4. Many local low-income people in the programs have performed well and have developed personally. Their training, however, has been limited, and high staff turnover has increased the need for training and exacerbated the difficulties of providing it. It is essential that more continuing, systematic, substantive, and sensitive training be provided for all levels of PCC staff.

5. Allied with the need for more and better training is the need for more and varied technical assistance. The wide range of fields in which these small centers are working necessitates the provision of technical assistance in administrative and management areas, child development, record keeping, family relations, health care, and social services. The technical assistance can best be provided by teams of experts assigned to serve a number of centers.

6. Cost records must be carefully maintained and operating and impact data consistently obtained. Since the demonstration is emerging from its start-up stages, it should be possible to begin to accomplish at least interim cost analyses.

7. The program has made many worthwhile accomplishments in its start-up phase. It is now appropriate to consolidate these accomplishments, to prepare to learn more systematically from this demonstration, and to take steps to improve efficiency of the operating phase being entered. Maintaining the program at about its current operating size probably affords the opportunity for improvement and observation necessary at this stage of the evolutionary process. However, greater resources should be devoted to training, technical assistance, health, and infant development components.

The text of this report, which follows, describes the PCC program, presents conclusions and recommendations at the end of each chapter dealing with specific aspects of the program, indicates some of the outcomes already achieved, and offers some broad conclusions and recommendations.

PREFACE

Before asking a reader to immerse himself in the statistics and generalizations of this report, we sought some way to give him a "feel" for what a center is like, and to put these observations into some general setting. To do this, we asked J. McV. Hunt to visit any center he chose, and to write us about his observations. Dr. Hunt, as Chairman of the White House Task Force on Early Childhood, has been credited as one of the fathers of the Parent-Child Centers idea. Yet, he has been an absent father--and has not been involved in the organization, development, or administration of the program which this report describes. Indeed, this paper by Dr. Hunt describes his first visit to a Parent-Child Center--a visit for which we deliberately provided no orientation. There are no "typical" Parent-Child Centers--but the center he visited has many of the features, strengths, and problems of most of the active centers.

Dr. Hunt is one of the country's leading authorities on the development of programs for young children--particularly children from impoverished families. A former President of the American Psychological Association, he is presently Professor of Psychology and Education at the University of Illinois.

REPORT ON THE PROGRAM OF PARENT-CHILD CENTER AT MT. CARMEL, ILLINOIS

by

J. McV. Hunt
University of Illinois
28 February 1970

Mrs. Earladeen Badger and I drove to Mt. Carmel, Illinois to examine the program of the Parent-Child Center for the counties of Wabash (county seat: Mt. Carmel), Edwards (Albion), Wayne (Fairfield), Hamilton (McLeansboro), and White (Carmi). Arriving just before noon, we met the director and his wife, who appears to be about as actively involved in the program as her husband, the assistant director who wrote the original proposal for the center to the Office of Economic Opportunity, and the following members of the professional and paraprofessional staff. Of the professional staff, we met: the registered nurse, the nursery school teacher, and another teacher. Both of these teachers were trained at the Child Development Center in the Department of Home Economics at the University of Illinois. Of the paraprofessional staff, we met: the receptionist-record keeper, her husband, who conducts the program involving fathers, and some seven teacher aides whose work we saw.

After lunch on Wednesday, we saw in action at Mt. Carmel the classes for children aged three to five, the Mothers' Club, the shop and plans for remodeling the home of one of the participating families; got the story of father involvement and how it started; got a verbal rundown from the director and assistant director concerning the history of the program and its present components not only at Mt. Carmel where an old school building serves as the center edifice, but the day-care center with preschool education at Fairfield, the meetings of parent groups in the four other counties, and the Outreach program of home visitors for rural families with children in each of the five counties. Finally, we toured Mt. Carmel and saw at least the outside of ten or a dozen of the homes of families participating in the program at Mt. Carmel.

On Thursday morning, we saw in action the class for infants aged seven months to 18 months, and thereafter that for infants aged 18 months to three years. Following lunch, with a discussion of the philosophy of and the progress of the center's program with the director and assistant director, we took a trip that took us by the building where the day-care center in Fairfield is housed, and we visited one farm home where we saw a teacher aide engage a two-year-old in educational games while the mother and a one-year-old child watched and conversed about the program with the teacher aide and us.

OBSERVATIONS ON THE PROGRAM

The Wednesday afternoon class for children aged three to five was fairly typical of nursery-school programs. This would be expected from the fact that the teacher in charge is a graduate of the Child Development Laboratory at the University of Illinois. The children present that day numbered 14. The teacher had two (or possibly three) teacher aides with her. These aides are mothers of families in the program who have shown some skill in the teaching and handling of young children. The tables used by this class, and also the other classes we saw, deserve some comment. They consist of semicircles of plywood 5/8" thick which are so designed that they can be cut from a standard sheet of plywood. They have the distinct advantage of enabling the teacher to keep eye contact with each of the children seated on the outside as she sits in the center of the circle. These tables and all the chairs that go with them were designed by the director and produced in the center's shop at minimal cost. The fathers are now engaged with the male aide in producing such equipment, but I am uncertain whether they actually produced these tables. This nursery school room also contained a cage of gerbils and a cage with two rabbits, one white, and one brown. The equipment included a good many of the kind employed in Montessori schools, some homemade, and some commercial. So far as the teaching was concerned, I would like to have seen more verbal interchange about the processes going on. Yet, I saw no evidence of lack of interest on the part of the children there, and an essential absence of behavior problems. I say "essential absence" because one boy did insist on lying under one of the tables for a time, but no one of the teaching crew paid any attention to him--a tribute to Mrs. Badger's counsel. Later, after the rest period, he resumed participation in one of the groups.

In the basement we saw a room fitted out for temporary child care where mothers can leave their children while shopping, running errands, or attending one of the mothers' meetings. Here the fittings apparently have come from the homes of people at Mt. Carmel.

We saw a storeroom where clothes contributed by people in the community are stored for the use of families in the program. We also saw the sewing machines which mothers are taught to use in order to remake these clothes contributed by the community or those outgrown by children within the families of the program. The mothers are also taught to copy patterns and how to use them in making clothes for their children.

The shop, also located in the basement of the school, is right well equipped with power saw, lathe, band-saw, and I have forgotten what else, along with hand tools. This shop has been used to involve the fathers. This involvement started on Christmas of 1968 or 1969, I have forgotten which, when it became evident that the children of the various families in the program would have no Christmas. The director's wife set herself the task of finding or designing kinds of educational toys which could be constructed in the shop by the fathers and mothers as Christmas presents for their children. The aide in charge of activities for men developed a kind of production line involving both fathers and mothers. The result was the production of 97 educational toys. These consisted of one piece of masonite as the back and another piece, glued to it, with cutouts into which various shapes such as trees, rabbits, etc. could be placed. These educational toys, colorfully painted, made highly suitable presents for the children. The operation also got the fathers involved in the program, and they have continued to be involved. Already they have combined, after the fashion of rural threshing crews and barn raisings, to remodel parts of the worst homes of families in the program. These remodelings have included the installation of indoor toilets, the tearing out of useless walls, papering and painting, etc. Most recently, the group has undertaken to tear down a house for the lumber in it. The workshop aide has drawn the plans for an addition on the house of one of the families in the program, and as the weather improves, the fathers will use their free time under the aide's supervision to construct an addition to the house of the most crowded family in the program. As we were told, the most satisfying aspects of this father-involvement is watching them gain skill and confidence as artisans.

The second floor of this center is fitted out with a kitchen. This kitchen is used as a place to prepare food served at various meetings, and also as a place to teach mothers how to prepare various inexpensive but palatable dishes.

The class for infants now aged seven months to 18 months is conducted in a room fitted out with a number of cribs, which are probably larger than they should be for ideal utilization of space, with infant chairs with play space in front, and with the floor surfaced with a rug. This room is supplied with a number of toys, some originating from CREATIVE PLAYTHINGS, some homemade, some designed for use at the infant chairs, some designed for pulling, etc. When Mrs. Badger and I came into the room, all but one of six infants were in infant chairs, but shortly, with our encouragement, they got to the floor with pull toys, balls, and noise-making roll-toys. Two teacher aides were serving these six infants. I saw signs of their calling for behavior outside the repertoire of infants so young. For instance, the infants in the group aged from 18 months to three years are called upon to put their toys back on the shelf when they have finished using them. The teacher aides in the room for younger infants, who are mothers in the program, occasionally called upon infants of about 12 or 13 months to put toys away. Even so, none of these infants under 18 months was tearful at any time while we were observing and playing with them, and all appeared interested in activities potentially educational much of the time. We saw absolutely no evidence of distress or problem behavior in this group of young infants, a point which argues strongly that separation from the mother need not be distressing or deleterious.

For the infants aged 18 months to three years, the program differed relatively little from that for children three to five. They worked with toys and with paper and crayon at the semicircular tables, they watched the rabbits, watched the gerbils, and seemed to enjoy showing us the various interesting things in their classroom. Again, my chief criticism of the program would be an insufficiency of concurrent talk about the activities under way on the part of the teacher and teacher aides. Again, in roughly an hour of observation, I can report seeing no signs of distress or behavior problems but many signs of behavioral interest and pleasure in the activities under way.

A meeting of mothers on Thursday morning was concerned with planning next steps in their program. I did not count the mothers present, but I would estimate that the number was somewhere between 10 and 14. It was fairly obvious that, being strangers, we were a distraction. As a consequence, I failed to get any very clear sense of the manner in which the group was operating. I did get a sense that they were enjoying their own company, and that the function was probably as much social as planful.

The day-care program for young children at Fairfield is under the direction of one of the nursery-school teachers. We had no opportunity to see this in operation.

In three counties and in rural areas of the other two, child involvement is limited to the home-visitor program called Outreach. We observed a teacher aide with a two-year-old in one of these rural families in Hamilton County. The home is that of a couple with two adopted children. We did not see the man of the house, for he is working at odd jobs with the goal of purchasing the 20 acres on which his house is located. The house is old, badly planned, but made livable by plywood and plasterboard over the presumably cracked plaster, and by plastic storm windows. The two children have been adopted, one a two-year-old, the other one year old. The house has a television on which "Sesame Street" can be got. The two-year-old and the mother watch it fairly regularly, and we were told that this infant has learned some of the counting, the jingles, and to recognize some of the letters.

The two-year-old was asleep when we arrived. Shortly after the teacher aide arrived, the mother awakened the two-year-old, and the teacher aide provided juice and began the "lesson." This began with presentation of the shape-sorting box from CREATIVE PLAYTHINGS. This two-year-old responded immediately by picking up the cylindrical shape and inserting it into the circular hole. She was then given the square block which, after some trial and error, she got through the square hole. Given the rectangular block, she put it through the rectangular hole almost without trial and error. Given the trapezoid, she struggled and struggled until the teacher aide helped her get it into the right orientation, and it dropped through the hole. With the triangular block, she failed completely until the teacher aide helped her orient it properly. When this operation started, I looked at my watch with the idea of timing the attention span. This child kept at this task of the shape-sorting box continuously for seven minutes. Moreover, she moved on to the next tasks with continued absorption through more than half an hour. During much of this time, the one-year-old was at her elbow observing the process with apparent interest. The mother was watching and discussing the program along with observing that the two-year-old was attracted by "Sesame Street" almost as much as she was attracted by the commercials on the TV.

THE PHILOSOPHY OF THE PROGRAM

In dreaming up the centers for children and parents as described in A BILL OF RIGHTS FOR CHILDREN, the members of the White House Task Force focused on the needs of the children rather than needs of parents. In fact, from what I have seen in various programs, I have gleaned that the love parents of poverty have for their children might well be employed to motivate parents to participate in a center program. The Mt. Carmel PCC, however, has started with needs of parents. This orientation began with the work of the present assistant director in preparing to write the proposal for the center. She visited and talked with various poor families in the five counties about what they would want from such a center as that comtemplated. Their answers focused upon their own needs rather than the needs of the children. When the director was employed, he too gleaned that the cooperation of parents would come most directly from getting their own most basic needs fulfilled. Thus, this center has elaborated its program by involving the parents in the planning and acting upon their expressed needs, and much of the program has focused on environmental improvement. Thus, the emphasis on early childhood education has come relatively late, and has been strongly fostered by Mrs. Badger whom the director had known at the University of Illinois while he was participating in the program of Mrs. Merle Karnes, and whose counsel he requested when he felt ready to focus on the needs of children. As I understand it, the day-care program in Fairfield of Wayne County, and the Outreach programs of home visitors in the other three counties have emerged to considerable degree through the influence and expertise of Mrs. Badger, the consultant from Urbana, who developed the program of teaching mothers to be teachers of their young children.

Mrs. Badger believes that the director and his staff have been slower than necessary in developing the educational aspects of the program for infants and young children. The director, by virtue of his upbringing in southern Illinois, has considerable empathy for the beliefs and feelings of the parents with whom he is working, and feels that he can move no faster than the parents are ready to move. Thus, the program at Carmi has been limited thus far to getting the poor adults of White County sufficiently acquainted with each other to permit joint planning.

There is probably no ready solution to this issue. In part it depends upon the convictions and the style of the leader. Mrs. Badger has been highly successful in convincing mothers that they can become effective teachers of their infants and young children. In teaching them to become such, she has got their cooperation in other programs as well. Whether such emphasis would ultimately lead to an elaborated program such as that now evident at Mt. Carmel is uncertain. It is clear that, as the educational aspect of the program loomed important, the director invited Mrs. Badger to become his chief consultant. The result is a highly active growing operation.

The philosophy of such programs will be highly important in their evaluation. If one focuses on chiefly the effects of such Parent-Child Center programs on the test scores and academic performances of the children, he may well miss aspects of the program which are necessary to develop the competence of the families as a whole and to lead them out of poverty. The involvement of the fathers is a case in point. They got involved in using the tools of the shop in order to make Christmas presents for their children. They were led to making repairs and minor renovations on some of the houses of families participating in the program. When they found a house through which they could get lumber by tearing it down, they planned an addition to the house of the most crowded family in the group. How far this kind of cooperation can go remains to be seen. It so happens that there is no building contractor in Mt. Carmel. If these 12 or so fathers who have heretofore known nothing but unskilled labor should acquire sufficient skill to enable them to enter construction, it is conceivable that this cooperative enterprise could lead to a commercial enterprise. The director and the workshop aide dream of such a possibility. Moreover, fathers so involved in constructive effort that results in tangible improvements in living circumstances can hardly help but be useful models for their children.

PARAPROFESSIONALISM

Although I failed to get the details of the staff of the Mt. Carmel Center, it is clear that it consists predominantly of paraprofessionals. The professional staff consists of the director, the assistant director, the nurse, the secretary, and two teachers.

I believe I saw seven of the mothers in the program serving as teacher aides and/or home visitors. What can happen through the use of participants in the paraprofessional role is illustrated by the young woman who serves as receptionist at the center. She was a divorcee when the program started, the mother of three children, who had completed only two years of high school. She started first as a teacher aide, and was then put in the job of receptionist. Through this encouragement, she undertook the examinations to get her high-school-equivalency diploma, and took a semester of course work at the Wabash Junior College. She has taught herself to type. She is given the responsibility of assembling the data on all of those who participate in the program, and she has the task of putting together the rough draft of the report. In the interim since the Parent-Child Center started, her first husband returned to the community after serving a decade as a mechanic of various kinds in the military services in the Pacific, and they have remarried. She looks forward to completing junior college, and he, who has had charge of involving fathers in the program, looks forward to getting his clients involved in construction.

This training function of the center, and perhaps of other centers, could well be improved by having a close tie with nearby junior colleges. Much of the training for teacher aideships could be deepened by the teaching of principles of child development and learning. The prospective teacher aides might well get college credit for their training. Thus, the tie between the center and the junior college could facilitate the development of the early phase of career paths which might terminate at skilled paraprofessional levels or go on to professional training.

STATISTICS OF THE PROGRAM

With the existence of the statistical reporting of Kirschner Associates, I made no serious effort to get a count of those parents and children involved in each aspect of the program. I sought rather an impressionistic picture of the program as a whole and of the prospects. Yet, I did learn that of the 39 families now served, approximately 15 reside in the Mt. Carmel area where the physical presence of the center is located. The director told me that this number amounts to something like 40 percent of those eligible by virtue of their income. From our examination of the houses in which the participating families lived, I can readily believe his statement that these participants represent the poorest families in the community and in the county. They are, however, all White. Few Blacks live in the counties served by this center, and one eligible Black family has refused to participate. I got much less of an impression of those served by the Outreach program and by the day-care center at Fairfield. With this number of participating families, I could not help but be impressed by the number of mothers present at the mothers' meetings and by the number of mothers who were serving as paraprofessionals in the program.

GENERAL EVALUATION

Since this is the first center I have ever visited, and since I have visited this one only once, evaluation must be based on a comparison of what I observed with my _a priori_ conception of what a program should be. On this ground, I was favorably impressed by the spread of the program, by the signs of its growing, by the intensity of participation in the program, and by the evidence of hopes for the future. I got little but reports of the staff concerning how the program is accepted within the community. Staff feel that the PCC is becoming accepted in Mt. Carmel. This was confirmed by the fact that the keeper of the motel where I stayed clearly knew about the Parent-Child Center and regarded it favorably as an innovation within the community.

Attempting to evaluate the Mt. Carmel Center has set me to thinking about the problem of evaluation. I wish I had known that community, as a social anthropologist might get to know it, before the center was established. I wish I had had an opportunity to visit the community for several days about four times a year. I would like to have plotted the development of the program, the development of the philosophy, the reaction of various categories of people within the community to the program. I would like similar evidence from many programs. Only from such evidence will it be possible to develop criteria for evaluating the process by which successful programs are developed. Only from such evidence will it be possible to examine the issue of whether the director and his staff is moving as fast as they might be moving in the context of the community his center is serving.

My own interests in evaluation are heavily concerned with what happens to the children. It is evident, however, that one can hardly expect to learn what the effects of such a program are by the test scores on the academic performance of children in such a program before it has been under way for three to five years. In fact, the ultimate effects could hardly be detected until the program has been under way long enough for the children in it to have reached the dropout stage at junior high school.

Nevertheless, during my visit in Mt. Carmel, we made plans for some minor evaluative studies. Several day-care centers exist in the community where no attempt is made to provide educational enrichment. One of the next steps in the development of program is to involve younger infants than those now involved. We have planned to utilize the Uzgiris-Hunt scales to assess the ages at which the children in these centers and those in the Parent-Child Center program achieve the successive stages of object construction and imitation. Similar studies can be conducted in the other counties as the program gets under way. Thus, while the ultimate evidence for evaluation must wait for several years of continued support, we can begin to get useful evidence on child development from relatively small comparative studies of programs under way.

Finally, as I compare what I saw at Mt. Carmel and in the home-visitor program with my dream of what the Parent-Child Center might be, I am favorably impressed. This center was planned in the spring and summer of 1968. The first staff meeting occurred on 18 October 1968. In view of how short a time this center has existed, the extent of the program, the quality of participation in it, and the prospects for growth constitute a fine achievement. Even so, the program needs to be extended at a similar level of participation to other counties, and the educational side of the program can be substantially developed. The teacher aides need to learn to talk more with children about what they are doing as they do it. They need to ask questions that encourage children to formulate matters in their own words. They need to involve infants at the center at younger ages than they are now involving them. The counsel and supervision of Mrs. Badger will undoubtedly help to bring these developments about.

CHAPTER I

INTRODUCTION

THE PARENT-CHILD CENTER PROGRAM

> In his message to Congress on Children and Youth, the President instructed the Director of the Office of Economic Opportunity to begin a pilot program of PARENT AND CHILD CENTERS (PCC). This program is to serve families in areas of acute poverty. The President also instructed the Secretaries of Health, Education and Welfare, Labor, and Housing and Urban Development to support these centers with resources from related programs.[1]

The Parent-Child Center (PCC) Program was developed as a consequence of this message to Congress. A national committee was formed to prepare goals and guidelines for the program. The goals defined for the program were broad and comprehensive as indicated by the guidelines prepared by the Interagency Committee:[2]

> In general, the PCC's are established to help families to function independently and effectively and for their children to develop to their full potential. In more specific terms, the programs developed by the planning groups should have the objectives of:
>
> 1. Overcoming deficits in health, intellectual, social, and emotional development and maximizing the child's inherent talents and potentialities;
>
> 2. Improving the skills, confidence, attitudes, and motivations of the citizens, parents, and individuals;
>
> 3. Strengthening family organization and functioning by involving the youngest children, the parents, older children in the family, and relatives;
>
> 4. Encouraging a greater sense of community and neighborliness among the families served by the center;
>
> 5. Providing training and experience for both professionals and nonprofessionals who may then be employed in work with parents and children;
>
> 6. Serving as a locus for research and evaluation of progress toward the objectives stated above.

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[1] Parent and Child Centers, OEO Pamphlet 6108-11, March 1969 (revision) Foreword and Introduction.

[2] Ibid.

The PCC program grew out of an increasing recognition that it is important to help children as early as possible in their lives. Experience with Head Start indicated that by the time many of these children were four or five years old, they were already damaged and disadvantaged by inadequate care, knowledge, and help. The strategy of PCC is to work with expectant mothers, infants, and very young children so that their physical, emotional, and intellectual development is encouraged. This program, unlike any other national effort, is designed to concentrate on families with children under three years of age.

It is important to recognize that the PCC program is a demonstration being conducted on a nationwide scale with a relatively limited budget. Organized programs focusing on infants are very few. Most informed people realize that little is known about working with such children and their families and, therefore, that it is necessary to increase our understanding of the organizational, community, financial, staffing, programmatic, and other factors involved. The PCC demonstration is an effort to increase our understanding in this field. This document, and the others that have preceded it, report on the demonstration and share the same goals, i.e., to enhance our capabilities to design and conduct effective programs for infants from low-income families.

Thirty-six communities were selected as sites for the demonstration PCC's. Groups in these communities were given grants early in 1968 to plan their programs with the thought that operations would start approximately during the summer of 1968. A small headquarters staff was established within Project Head Start in Washington, D. C. to administer the program. This staff reviewed program grant applications, made funding decisions, and subsequently was responsible for the general development and control of the program on a national basis.

THE NATIONAL EVALUATION

Consistent with the concept that the PCC program is a national demonstration, funds were made available to study this program to determine what has been learned from its first year of operation. The Methodology chapter describes in detail the philosophy and approach of this project and the methods used to conduct it. The project contained two principal requirements:

(1) To design, develop, and operate a national PCC reporting system that would obtain data from Centers, process them, and provide them to PCC-Washington on a periodic basis.

(2) To describe and assess the PCC program and to make such recommendations as are appropriate.

These two requirements were interpreted to this firm by the Interagency Committee responsible for monitoring the contract, as subsequently described, and the project complied with these interpretations. The principal objective of the undertaking continues to be to help present what has been learned as a result of the first year of the demonstration. The perspective of this evaluation is national; individual centers are regarded as illustrative examples of a national program. Thus, it is hoped that this report will be of particular value to national officials responsible for policy, financial, and program decisions on a national basis as well as to others more concerned with local operational questions.

CHAPTER II

METHODOLOGY

INTRODUCTION

General Approach

This project was conducted under the general supervision of the Interagency PCC Monitoring Committee composed of staff members of and consultants to several federal agencies (OEO, Labor, and HEW). The Monitoring Committee took the view that this project was to be neither research nor evaluation in their generally accepted senses but was to be a study of "inputs"--not of "outcomes." This approach is based on the premise that the kind of results that can reasonably be assessed at the beginning of this type of developmental program are those related to such descriptive questions as:

--What services were provided?

--What kinds and numbers of staff were employed?

--What types and numbers of families were served?

--What can we learn from this experience that will be useful in launching new centers or related types of programs?

This approach does not seek to answer questions dealing with the effectiveness of the programs undertaken or the wisdom of continuing, expanding, or terminating the program. These questions, the Committee decided, could only be answered intelligently after the program left its start-up stage and became more stable and fully operational. Further, this permits time for individuals served to be affected by the programs. Thus, this project is primarily descriptive.

It is because of the overall approach decided upon by the Monitoring Committee that the project was designed and conducted as subsequently described. In no case did it focus on determining outcomes and seriously attempting to relate these outcomes to the interventions (programs) in the various centers. Neither did the project focus on carefully assessing the quality of the various programs offered.

Although the PCC program as a whole is considered a demonstration, it was not designed as an experiment to demonstrate the effects of different predetermined organizational strategies, intervention techniques, or any other particular factors. Each center has been encouraged to evolve its own program in the hope that the results will be particularly sensitive to local conditions and that some new and effective approaches may result. A demonstration designed in this way, and particularly a relatively small and new one, is not particularly amenable to sophisticated or rigid research and evaluation. Other factors, as indicated later in this section, also inhibited conduct of a "tight" project.

Schedule

This project was started in March of 1968, before any of the centers had received their operational funds. It was planned that the first six months of the project would be devoted principally to design activities, the next year would focus on the first program year of the 36 centers, and the final six months would be occupied with data analysis and preparation of the final report. The principal difficulty with this schedule was that not all of the centers started their operational years promptly or simultaneously. Thus, program investigations started in some centers much later than in others. Also, investigations were completed in some centers only recently.

This project has taken two years. During this period, substantial monthly reports have been submitted as well as detailed quarterly reports. Frequent contact has been maintained with the Monitoring Committee, the PCC Washington staff and the Research and Evaluation staff of Project Head Start.

Data Sources

The data presented in this report have been derived by three principal methods, which are discussed in the following parts of this section. These methods are: (1) a reporting system devised by Kirschner Associates, Inc. (KAI) and utilized by PCC's to transmit basic statistical data; (2) visits to PCC's by KAI's own staff and field research associates who then prepared periodic descriptive and analytical reports of their observations; and (3) developmental examinations of 109 infants and toddlers at six centers and re-examination of 79 of them 40 weeks later. Information was also obtained from the national PCC staff members and their Project Advisers and from various meetings of center staff, directors, and advisory board members.

THE NATIONAL PCC REPORTING SYSTEM

Design of the System

One of the requirements of this contract was that the firm design and administer a national reporting system for all PCC's. The arrangement was that KAI would be responsible for design of the system, preparation of all necessary reporting forms, and provision of these forms to the centers. The centers were required to designate one regular staff member as a part-time "Data Coordinator" responsible for compiling and submitting the data necessary for the national reporting system. Data coding, processing, and analysis were the responsibility of the contractor. Thus, this is a "self-reporting" system in that the centers themselves are responsible for providing the necessary information about their own activities.

When the information and reporting system was devised it was to be the only PCC reporting requirement aside from a simple budget report. Subsequently, this proved not to be the case but the data system was devised to satisfy the requirements of the PCC staff in

Washington as well as those of this project. These reporting forms were tested and then distributed to the centers. Reporting requirements were subsequently revised based on field experience and federal requests for additional data.

The data system was designed to collect identifying and demographic data about each family served, selected health data on each child under three, financial data, and information about the goals, policies, facilities, and activities of the centers. While not required by this contract, data were collected in such a way as to permit later follow-up studies of program participants should this be desired. Forms were also provided on which to report terminations of staff and families and medical contacts with children subsequent to initial examinations. Most reports were on a one-time-only basis; several were quarterly, and a few were semiannual. It was estimated that reporting would not require more than a few hours a week of center staff time after the initial reports were prepared at the beginning of each center's operational phase.

Comments Concerning Operation and Reliability of System

Much of the statistical information contained in this report is based upon the data collected in the National Reporting System. Some comments concerning the actual operation of this system are therefore presented.

1. As often seems true, service personnel resisted "paperwork" and forms. Concerned with the immediate problems of children and their families, reports and record keeping were seen as bothersome and unrelated to their service tasks. This "usual" resistance was true for many PCC staff members. Because this was anticipated, the forms were designed to be as simple and short as possible, sacrificing the economy of precoded forms for the appearance of

brevity. For those forms that asked for data which a center would normally want for its own files, color-coded duplicate sheets were provided so that carbon copies would be made automatically.

2. A second kind of resistance came from urban militants, who found data collection a convenient and safe target. Unconnected with the funding process, seen as the requirement of a private firm and not as a federal requirement, the reporting process provided a "free" base for the expression of hostility and a symbol of the majority "establishment." Since the federal representatives did not, until quite late in the project, identify themselves with the reporting system, and only sporadically insisted upon reporting, enormous amounts of time and money were spent by the project staff encouraging data collection and interpreting its need.

3. Poor people--particularly in the major cities--are often afflicted with an abiding suspicion of all authority. Convinced that all arms of government are interconnected, many were unwilling to provide any information about themselves, for fear that their welfare checks and eligibility would be impaired. This fear, coupled with the militants' claims--in a few cities--that the purpose of the data was to identify Black babies for extermination, made many parents initially wary of answering any questions. Most directors were able to allay these fears, but several directors, resisting paper work--and data disclosure--did little to discourage these fears. One director flatly refused to distribute the forms, feeling that they represented a violation of privacy. Two have never returned any data forms whatsoever. The only information from these centers was gathered by central office staff.

An interesting source of difficulty in a few centers arose from what this contractor considered an act of generosity. Realizing that each center would need generalized Release of Information Forms for use in obtaining and providing medical records, emergency medical care, and so on, such a form was provided. Rather than understanding and interpreting the need for such a release--essential to the center but not to the contractor--this release, in its generalized language became an issue in itself; one Black parent, for example was convinced that it would allow the government to take her child away.

4. As previously indicated, when the information and reporting system was devised, it was the contractor's understanding that, aside from a simple budgeting report, the Parent-Child Centers would have no other reporting requirement. Funded directly from Washington as demonstration grants, there seemed no reason why the usual forms used by so-called "versatile funds" grants by Community Action Agencies would be either necessary or appropriate for these projects. Therefore, all of the management information which Washington would need was incorporated in the reporting system. This understanding was never transmitted to the CAA's through whom the PCC's received their funds, who then required that the PCC's not only conform to CAA reporting, but also to their Regional Office Program Planning Budgeting System planning requirements. As a result, PCC's wound up needing to make separate reports--on different forms, to:

--their delegate agencies
--the local CAA
--the Neighborhood Service Program (in 14 cities) and its national reporting system
--the OEO Regional Office (through its CAA requirements)
--the PCC National Reporting System (through KAI)
--their local university evaluation programs

This burden of frequent, but not exact, duplication of reporting was, as is discussed elsewhere, accompanied by almost as many layers of administrative relationships, and aroused understandable resistance to the whole idea of reporting and forms. Since KAI's forms were the only ones not connected with receipt of PCC funds, they seemed to be given the lowest priority for completion. Given the sheer bulk of reporting that fell upon the PCC's, it would seem (from their point of view) that this was a reasonable ordering of the priorities.

5. Some of the data required by headquarters seemed irrelevant to the local centers and their staffs. Chief among these were the data and categories contained in the report of Health Status. These items were selected by the Head Start pediatrician, and were taken directly from the Head Start medical examination reporting form. In our judgment, these were, in part, inappropriate to the age group of PCC youngsters; they did not parallel the way in which medical students are taught to conduct and sequence a pediatric examination; and they were not connected to payment of a fee. The format and data suggested by our pediatric consultants were not acceptable to Head Start; the Head Start items we used were not acceptable to many of the practitioners who served the Centers; the result of this impasse was a low rate of return.

6. While the idea of a Data Coordinator--one regular staff person assigned the task of filling out or distributing, collecting, and returning reporting forms--seemed a good one, in practice it was not often successful. Some centers did, in fact, assign the task to a secretary or bookkeeper. On the whole this worked quite well. Some center directors kept the task themselves, perhaps to control disclosure, and then were too busy to get the task done. Some centers assigned the task to their social workers or University Affiliates, who often were also too busy to serve as data clerks.

Many centers used the task to create a new job for an indigenous aide. This was the least satisfactory arrangement. Sometimes too poorly educated to understand the reporting categories, often unacquainted with the need for accuracy or the personal discipline involved in data reporting, and frequently seen as a "poking peer" rather than an administrative functionary by parents, the aides produced the least current, least complete, and least valid forms. Coupled with clerical ineptitude was the complex of suspicion and low priority which we discussed earlier. As a result, little confidence can be placed in the validity or reliability of the data received from the indigenous data collectors. This is particularly true of reports from the inner-city programs. The aides were knowledgeable about OEO requirements, disdainful of them, and suspicious of the government. Their data forms often include inconsistent and inconceivable reports: a 21-year-old staff member, for example, the mother of three, reported 15 years of higher education and administrative experience.

7. Finally, some directors refused to submit data which, in their view, would reflect negatively on their performance.

In view of the vicissitudes described, the reader must be aware that the contractor does not have a high order of confidence in the statistical data that were provided by the centers through the National Reporting System. Fortunately, this information was supplemented by reports of KAI's own staff and field research associates based on their personal observations at the centers.

REPORTS OF KAI PROFESSIONAL STAFF AND FIELD ASSOCIATES

Design of the System

A corps of 39 experienced professionals in child development, pediatrics, child psychiatry, child psychology, sociology, social work, cultural anthropology, education, and management periodically visited and reported on each of the 58 Parent-Child Center sites. Because the starting dates, complexity, and quality of local reporting varied so greatly from center to center, the number of hours devoted to each center was deliberately uneven, to maximize the richness of observation within a budget that had not anticipated that centers would be permitted to establish multiple sites, often distant from each other. (In Alaska, the PCC sites were one thousand miles apart, but administratively these two sites are considered to be one Parent-Child Center.) These observers, called Field Research Associates (FRA's), include some of the country's most distinguished authorities in infant and early child development fields. They devoted an average of 100 hours to investigations related to each center.

Table 1 lists the FRA's, their specialities, and their home bases. They include several members of KAI's central staff.

TABLE 1

FIELD RESEARCH ASSOCIATES

Name	Specialty	Home Base
Joseph Albini, Ph.D.	Sociology	Detroit, Mich.
Francis S. Barham, M.D.	Child Psychiatry	Berkeley, Cal.
Edward T. Beitenman, M.D.	Pediatrics	Omaha, Nebr.
Raymond Bixler, Ph.D.	Social Psychology	Louisville, Ky.
Grace Brody, Ph.D.	Child Development	Cleveland, Ohio
Susan Brown, Ph.D.	Child Psychology	Los Angeles, Cal.
Bettye Caldwell, Ph.D.	Child Psychology	Little Rock, Ark.
William E. Cole, Ph.D.	Sociology	Knoxville, Tenn.
William Davis, Ph.D.	Social Psychology	Anchorage, Alaska
Cynthia Dember, Ph.D.	Child Psychology	Cincinnati, Ohio
James F. Doyle, Ph.D.	Child Development	Atlanta, Ga.
Ronald Ebert, Ph.D.	Child Psychology	New York, N.Y.
John Eichenberger, Ph.D.	Social Work	Louisville, Ky.
Gillian Foster, M.S.	Psychometrics	Los Angeles, Cal.
Albert Gardner, Ph.D.	Child Development	College Park, Md.
Arnold Gerall, Ph.D.	Psychology	New Orleans, La.
Elaine Gethard, M. Ed.	Early Childhood Education	Los Angeles, Cal.
Ira Gordon, Ph.D.	Child Psychology	Gainesville, Fla.
Gary Green, B.A.	Public Health	Los Angeles, Cal.
Edward Greenwood, M.D.	Child Psychiatry	Topeka, Kans.
J. Mc V. Hunt, Ph.D.	Child Psychology	Urbana, Ill.
Anne Kirschner, B.A.	Early Childhood Education	Albuquerque, N.M.
Richard Laskin, Ph.D.	Sociology	Chicago, Ill.
Joyce Lazar, M.A.	Sociology	Los Angeles, Cal.
Ruth Matarazzo, Ph.D.	Clinical Psychology	Portland, Ore.
Howard Mitchell, Ph.D.	Psychology	Philadelphia, Pa.
Lois Barclay Murphy, Ph.D.	Child Development	Washington, D.C.
David Norsworthy, Ph.D.	Cultural Anthropology	Walla Walla, Wash.
Henry Platt, Ph.D.	Special Education	Devon, Pa.
Albert Ramirez, Ph.D.	Social Psychology	Birmingham, Ala.
Marshall Rogers, M.P.A.	Community Planning	Oklahoma City, Okla.
Clarence Rosecrans, Ph.D.	Clinical Psychology	Birmingham, Ala.
Judy Rosenblith, Ph.D.	Child Psychology	Brookline, Mass.
Nancy Sandusky, B.A.	Psychology	Albuquerque, N.M.
Douglas Schramel, M.D.	Psychiatry	Honolulu, Hi.
Marion Seifert, M.S.W.	Social Work	New York, N.Y.
Lawrence Uno, M.S.W.	Social Work	Honolulu, Hi.
Thomas Walz, Ph.D.	Sociology	Minneapolis, Minn.
James Wiebler, M.S.	Sociology	Minneapolis, Minn.
Michael Zunich, Ph.D.	Child Psychology	Carbondale, Ill.

Comments Concerning Operation of the System

The system of reporting by professional personnel, either on the staff of the firm or associated with it, worked approximately as anticipated. Problems of various types were anticipated and encountered in visiting centers scattered from Hawaii to above the Arctic Circle in Alaska and from urban ghettos to rural back reaches.

Field observations were conducted on a periodic basis. Field associates were provided a series of outlines indicating the types of information required, several observation and interview schedules, a description of the national program, and a copy of their PCC's proposal. They wrote reports after each visit and a selected number were asked to prepare final reports which have been provided to the Office of Child Development.

While general reporting outlines and rating scales were provided the field associates, instructions were deliberately broad. Since they were experienced practitioners and researchers, it was undesirable to impose the firm's own categories in their thinking. This approach imposed the usual burdens of dealing with anecdotal material but it was selected as more valuable in dealing with emerging programs than would be a more structured or quantitative approach. Further, it was anticipated that the field reports would be supplemented by, but would not be a substitute for, quantitative data provided by the centers using the National Reporting System.

Use of a loosely structured approach involving experienced professionals as observers and reporters seems to have had considerable merit in this project. It is also important to note that the field personnel were generally located near and knowledgeable about the center environment. Thus, they brought to the project not only their professional competence but closely related and valuable background information. The reports of the field investigators presented some problems because of the varied interests and perceptions of the authors. These reports, however, are exceedingly rich in detail, insight, illuminating anecdotes, and other materials that provide the flavor of the centers--their settings, problems, and achievements. An average of 100 hours per center was devoted by the field staff members to their investigations and report preparations.

One of the hazards of utilizing the approach described above was that many of the centers attempted to use the field staff as consultants and sources of technical assistance. Hungry for help, the centers sought it where it was available. Generally this was not too severe a problem and it is believed that the professional judgment of KAI's field associates was not tarnished by the fact that they occasionally complied with requests for guidance and advice.

While KAI's observers were, on the whole, readily accepted by center staffs and directors--and in some cases were cast in the role of cathartic agent--certain FRA's did have difficulty in establishing rapport. In one urban ghetto, a militant PCC chairman forced the resignation of both the federal Project Adviser and KAI's field person by his abuse of them as Caucasians. When a Black professional was sent in as field observer, the hostility appeared to be less racist in origin and more a function of insecurity. In general, the less active, slower starting PCC's tended to be more resistant to visitors. The more active centers tended to welcome observers with pride in their accomplishments. There are, of course, exceptions to both of these generalizations.

It was evident that the field staff researchers seemed to share a common bias "in favor" of the PCC's in rural settings. These researchers were continually touched by the almost unbelievable rural poverty and were impressed more by even minor accomplishments in these barren environments than by more active centers in urban areas with many resources.

Using the staffing pattern selected for this project (a central, full-time staff and part-time, resident field research associates) does have administrative problems. Some of these problems could be overcome by utilizing only company personnel to do all the field work. On balance, however, the pattern used for this project, in spite of the problems encountered, did provide an enormously valuable variety of insights and understanding.

DEVELOPMENTAL EXAMINATIONS OF INFANTS

Utilization of the Bayley Scales in this project is described in detail in a later chapter of this report. This particular scale was selected because it was deemed particularly useful in this context, and also because of awareness of the suspicion with which tests are perceived in some poor neighborhoods. The Bayley--unlike most other infant scales--requires the mother's presence, a fact we saw as valuable in allaying such suspicions as well as having educational value for the mother. But it seemed to us that selecting an appropriate scale was insufficient precaution; the psychometrist had to be someone who had demonstrated skill and experience in working with poor mothers and many ethnic groups. We selected a woman who had had extensive nursery school experience, graduate clinical training in work with disturbed preschool children, and who had worked as a teacher, head teacher, and training teacher in Head Start programs serving Mexican-American, Anglo, and Black children. We then sent her for training to Dr. Bayley's staff, where she learned the use of the Scales from their authors. Dr. Bayley and the Psychological Corporation made sets of the equipment available to us before their publication so that the pretest could get under way. The choice of psychometrist, her willingness to explain and demonstrate procedures, her knowledge of program operations and programs for the poor all contributed to make this a smoothly operating activity, which centers and parents both accepted and enjoyed. Many of the centers have asked for continuing psychometric service. Aside from their utility in individualizing instruction, we believe that tests can be uniquely valuable in future outcome studies--but should be collected by a person unconnected with the center itself. The two centers to whom we provided test kits and forms for their own use produced unusable data because of their own involvement and responsibility to the center.

SUMMARY

It should be understood that the central project staff were involved with every aspect of the project: design, all three types of data collection, analysis, and report preparation. Thus, they were administratively responsible and substantively involved throughout. The methodology described above and later in this report served the purpose of a descriptive study of program development and inputs. These data would not serve for a study of process and outcomes. For such future studies more time, more controls, and more structured procedures would be necessary. Such an outcome study will be required for a more scientific assessment of PCC's as they evolve.

CHAPTER III

ORGANIZATIONAL DEVELOPMENT OF THE PARENT-CHILD CENTERS

THE NATIONAL ORGANIZATION

The Parent-Child Center (PCC) Program was established as a separate organization within Project Head Start which was a part of the Office of Economic Opportunity (OEO) and recently has been included within the Office of Child Development, Department of Health, Education, and Welfare. For most of the period of the evaluation project, the PCC program has been directed by a Washington staff, known as the D. C. Coordinators, of three persons drawn from Project Head Start. In addition, each location selected for a planning grant was assigned a person initially designated as a Project Officer but now known as a Project Adviser. These Project Advisers were made available to the centers four days a month through a contract with VOLT Technical Corporation. They are responsible to the D. C. Coordinators. Essentially they are a part-time field staff of the Washington office of PCC. Many not only helped to develop the initial proposals but remained with the PCC's as advisers in the operating stages.

Project Advisers were deliberately chosen to help develop PCC's in locations far from the Advisers' homes or areas of professional activity. The concept was to avoid involving professionals in programs in communities where the professionals already were known and had involvements and commitments. The result was often that the Advisers had to travel a great deal to help the centers, were not convenient to the centers for continuing informal consultation, and were not possessed of valuable information about local conditions and community resources where the PCC's were located.

EARLY DEVELOPMENT OF THE PARENT-CHILD CENTERS

The Planning Period

An initial six-months planning grant of $10,000 was made to the CAA's of each of the 36 communities selected for the pilot project. The CAA developed a planning committee composed of representatives of local health, educational, and welfare agencies; other professionals and residents of the target area; and eligible parents with a child under the age of three years. This planning committee then set about surveying the resources and the needs of the community. Many did a door-to-door survey to locate eligible families. The committees established selection criteria for the families to be served, coordinated community arrangements to meet the local needs of the families, and made plans to develop programs to fill the gaps in available community services.

The first year proposals submitted to PCC-Washington for funding included commitments from various agencies and community resources pledging support services as well as plans including the following specified criteria:[1]

1. An outreach recruitment and admissions process which would guarantee that selected families are economically disadvantaged.
2. Comprehensive health care for the child, plus sufficient health care and health education for parents and siblings to minimize any negative effects on the child, as well as family planning and prenatal care.
3. A program of activities for the children designed to stimulate their physical, intellectual, and emotional development to the maximum potential.
4. Parent activities designed to strengthen their:
    - (a) Understanding of child development;
    - (b) Competence as family managers;
    - (c) Skills essential to making a living, including maximum opportunities for employment within the PCC;
    - (d) Self-confidence and self-image as parents;
    - (e) Intra-familial relationships between husband and wife (where both parents are present) and between parents and children; and

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, pp. 4-5.

   (f) Definition of the male role within the family.

5. Social Services to the entire family.
6. A program designed to increase the family's participation in the neighborhood and the community both in terms of:
    (a) Taking advantage of the opportunities it offers, becoming familiar with and knowledgeable of its resources, and
    (b) Stimulating the family to become participating, responsible, and significant members of the neighborhood and community.
7. A training program for both professionals and nonprofessionals. This program must have the capacity initially to train personnel for the specific PCC, but must be capable of training additional personnel at a later date. It must also include the recruitment and training of volunteers of many age groups and neighborhood residents to work alongside the professional staff.
8. A program of research and evaluation developed in cooperation with an appropriate institution, such as a University or a Clinic, and designed to:
    (a) Describe what happens in the center and provide necessary statistics on operations;
    (b) Measure developmental progress in the child, parents and other family members and community;
    (c) Result in recommendations on program content and methods;
    (d) Produce packaged instructional materials and handbooks on how to operate this type of program; and
    (e) Adequately assess the operational costs of running similar programs.

It is expected that each center's E & R program will be related to a comprehensive research and evaluation subcommittee organized by OEO, the Children's Bureau, Public Health Service, and the Office of Education of the Department of Health, Education, and Welfare.

Additional program elements will be considered on their merits.

As might be expected, the combination of the provision of general guidelines by the national office and the planning of programs under very different circumstances resulted in a wide variety of applications. It was indeed intended that this might happen and it was hoped that the various programs proposed would represent different solutions, utilizing different local resources to solve different local problems. Following chapters of this report describe the various programs that evolved from the planning stage and it is fair to say that they do tend to differ quite markedly although there are also some marked similarities. The similarities are in part a function of the national guidelines and partly a function of the national grant application review and funding process. Additionally, each center has approximately the same budget, which narrows its range of alternative approaches.

The Communities Selected for PCC's

The 36 communities given planning grants were selected to include great geographic spread and a range of urban-rural locations, ethnic and cultural diversity, and of available resources. Included among the centers were 25 urban communities, and 11 broadly classed as rural. These can be divided by approximate geographic location in the following way:[1]

Northern and Western Urban

Los Angeles, California
*Oakland, California
Honolulu, Hawaii
*Chicago, Illinois
Baltimore, Maryland
*Boston, Massachusetts
*Detroit, Michigan
*Minneapolis, Minnesota
*St. Louis, Missouri
*New York, New York
*Cincinnati, Ohio
Cleveland, Ohio
*Philadelphia, Pennsylvania
Washington, D. C.
Newark, New Jersey
Omaha, Nebraska

Southern Urban

Birmingham, Alabama
*Jacksonville, Florida
Atlanta, Georgia
*Louisville, Kentucky
Chattanooga, Tennessee
Houston, Texas
*Dallas, Texas
New Orleans, Louisiana

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[1] Those centers marked with an * are funded through a Neighborhood Services Program.

Rural

Hoonah and Kotzebue, Alaska (villages)
La Junta, Colorado
Dalton-Summerville, Georgia
Carmi, Illinois
Hardinsburg, Kentucky
Fayetteville, Tennessee
Barton, Vermont
Huntington, West Virginia
Menomonie, Wisconsin
Pasco, Washington (Migrant Camp)
Pine Ridge, South Dakota (Indian Reservation)

The selection of the 36 communities for demonstration programs is of importance for two reasons. First, it is interesting to note that of only 36 programs, two are in Kentucky, two in Georgia, two in Tennessee, and none in some states with equally impoverished areas. More important, however, is that some of the selected communities do not have the resources and conditions necessary to support a program as comprehensive as PCC. As one of our field staff writes,

> Neither of the two sites selected has "support" services. The nearest doctor and dentist are approximately 30 miles away....Many children grow up without ever seeing a doctor and a large number of adults very obviously need extensive dental work. In one community the school system has been cooperative, but in the other the superintendent of the grade school has attempted to force the PCC out of the community and children have been beaten because of their parents' involvement in community action programs.
>
> There is no Head Start program in either community and generally OEO programs have been unsuccessful--either promised and never developed or started and dropped.
>
> In one community, the library does not permit children to take books home....There is not a variety of stores in which to make purchases in either community and the people are pretty much at the mercy of a couple of merchants.

Further, sites do not appear to have been selected on the basis of any criteria related to testing various hypotheses that might be associated with the "demonstration" aspects of the program.

As it developed, four diverse characteristics of different communities hampered the development of the PCC's.

1. Some communities selected did not have sufficient resources to support a PCC.

To satisfy the comprehensive program criteria established for the PCC's, medical, social service, and professional manpower and a base of welfare support were necessary. At least six of the communities selected were deficient in several of the resources the PCC's were expected to coordinate.

2. Some communities selected did not have sufficient eligible families in the target area specified.

At least three PCC's have had to devote a disproportionate amount of time to continuing efforts to identify and locate sufficient eligible families within the area selected for PCC service.

3. PCC's funded through the NSP's did not have anticipated services available on time.

Development of the PCC's funded through the NSP's was delayed because the service centers had not yet developed or established guidelines, personnel, fiscal policies, or facilities. It was anticipated that the NSP's would facilitate the development of the PCC's, but actually in many cases the PCC's became active before the NSP's.

4. Bureaucratic delays in large cities were increased by the many layers of administrative structure associated with the PCC's.

Schedule of Program Funding and its Implications

After the planning period, which for some centers extended from the anticipated six months to more than two years for the one center not yet funded, proposals were submitted and grants made to 35 locations by December of 1969. Of the 35 funded, grants were made to two state OEO's, one Title III Migrant grantee, to the CAA's or their delegate agencies including three universities, two long-established social work agencies, and 13 of the Neighborhood Service Programs. The one center not funded during this period is Dallas, the fourteenth PCC designated for NSP affiliation.

Funding was delayed because a number of the proposals showed deficiencies either in coordination of service; the involvement of target area residents; a lack of development of a comprehensive plan, particularly for the delivery of medical services; or in finding the required community contribution in space or funds. The first year's grant to the PCC's of $175,000 was to be matched with a 20 percent local contribution. Until communities met the criteria or showed indications of being able to meet them in the future, funds were not released. The variation in dates for the release of operating grants is shown in Table 2.

TABLE 2

Release of PCC Operating Grants

Date	Number of Centers
May 1968	1
June 1968	7
July 1968	19
August 1968	1
October 1968	1
February 1969	1
March 1969	2
May 1969	1
June 1969	2
Not released as of December 1969	1
	36

The length of time required for a PCC to move from paper plans to services for children and families is shown on Graph 1. These variations are related to the location of the community, to the auspices through which the PCC is funded, to whether or not the PCC planning committee had arranged for a facility to house services, and to whether or not families were recruited prior to submission of the proposal.

Location

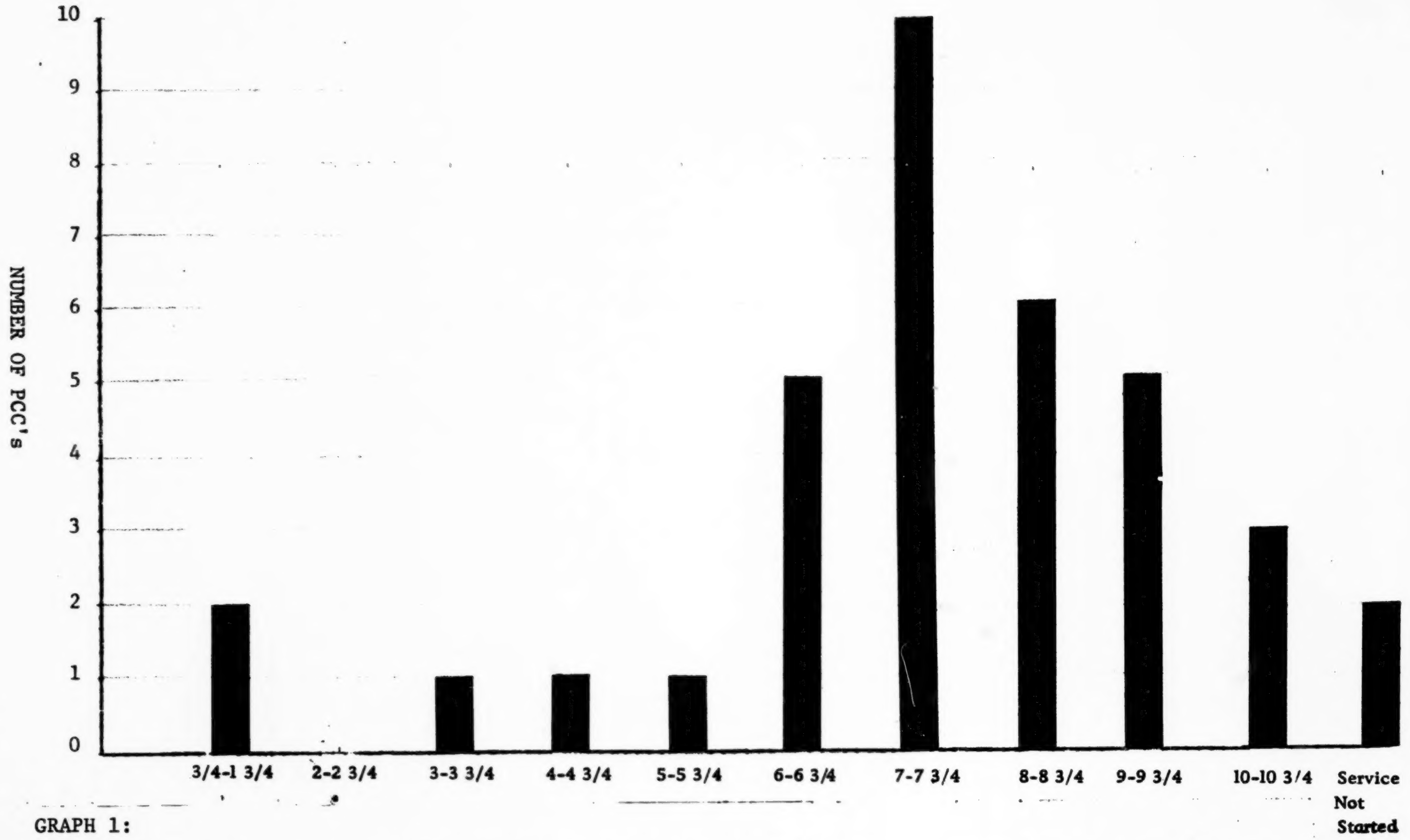
The rural centers were nearly twice as likely to begin to deliver services to families within the first seven months after release of the operating grant than urban centers. The 11 rural centers have been serving families an average of 13.6 months, and the urban centers an average of 10.9 months.

Auspices

Those PCC's funded through a new agency, that is, where the Policy Advisory Committee became incorporated to receive funds, were able to deliver services to families earlier than those with an additional organizational structure such as an NSP, a university, public school system, or a traditional social work agency. Existing agencies, universities, and even the newly developing NSP's have their own sets of bylaws, guidelines, personnel policies, and fiscal reporting requirements into which the PCC program with its own federal requirements must be adapted. It is not surprising to find that a longer period of negotiation and arrangement is required to fit a PCC into an existing structure than to create a new one. Even by December of 1969 the one PCC not yet funded was delegated through an NSP as was the one center that had employed staff, but had not yet initiated services to families.

Facilities

A prior arrangement for space appears to have been of great importance in how soon after funding a PCC was able to implement



GRAPH 1:

NUMBER OF MONTHS BETWEEN RELEASE OF OPERATING GRANT AND INITIATION OF SERVICE TO CHILDREN AND FAMILIES services. Nine of the 11 PCC's that made arrangements during the planning period for the use of space were able to implement their programs within the first seven months if only on a limited basis. Some of the PCC's that could not locate space did begin limited services in the homes of clients, but only two of the 13 centers that did not arrange for some kind of facility during the planning period were able to implement their programs within seven months. Perhaps no issue occupied so much of the staff time during the early months of funding that the problem of locating a facility, negotiating a lease, contracting with repairmen, and purchasing equipment while at the same time trying to train staff, develop program, and recruit families. These problems were often made more difficult since few PCC directors had prior experience in negotiating leases or contracting for building renovations. Before children could be brought into most of the facilities located, extensive renovations had to be made, and these of course delayed the implementation of the program. As one of the field staff reported,

> The PCC is housed in the former South Elementary School. The building had been closed for fifteen years before the staff moved in and was in deplorable condition. The roof leaked, the bathroom floorboards had rotted away, and there was no heat. Except for the flooring, however, the building was structurally sound and promised to make an attractive center once it was renovated....The director was able to have several gas space heaters installed soon after the staff took possession of the building, but little else was done during a long period of negotiating with the CAA over the renovation contracts. Months went by before the work was even begun, and the building was not really ready for the program until late in the spring of 1969. One index of the hardship this situation worked on the staff and the PCC program is the fact that they did not even have a bathroom to use.

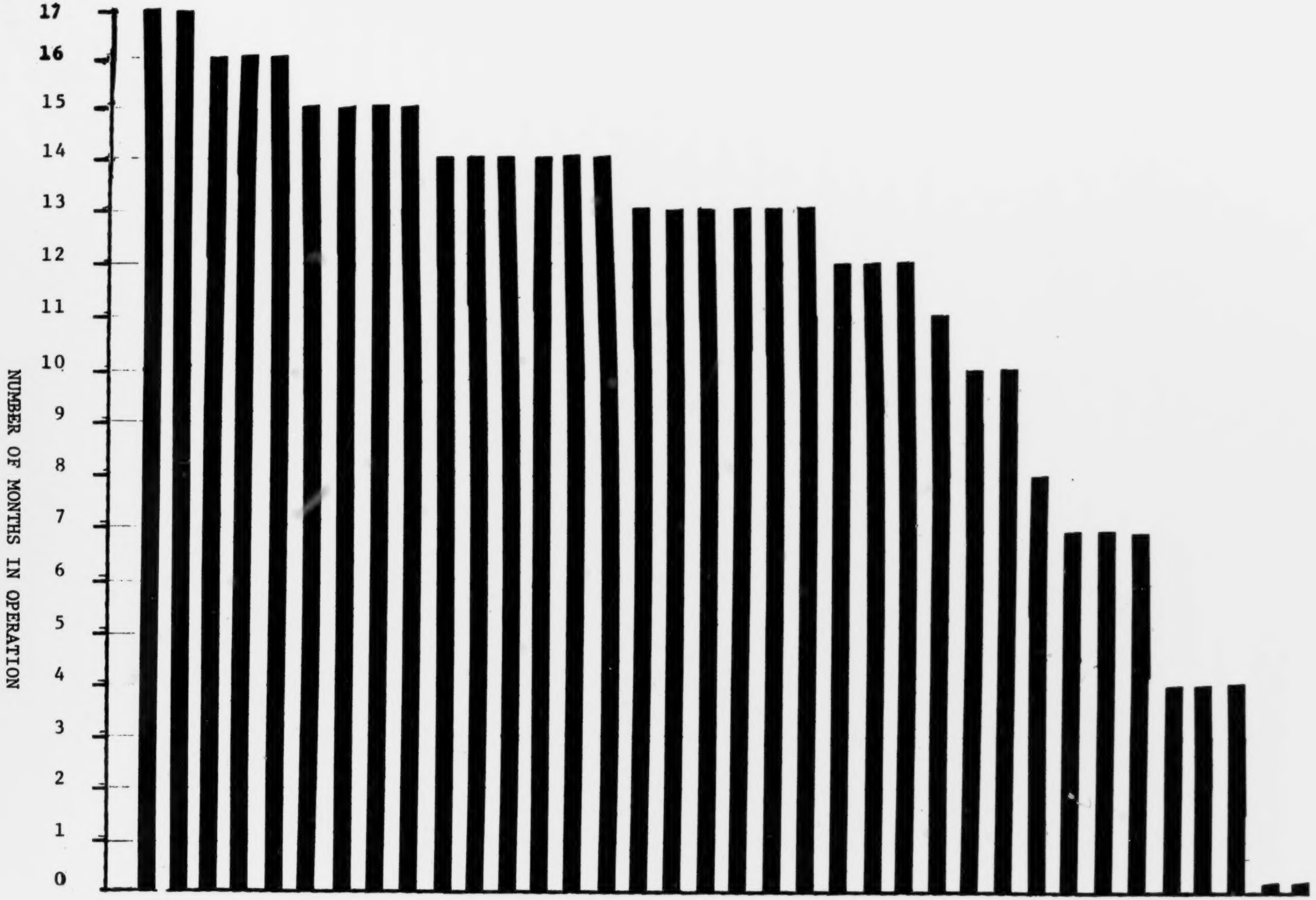
Another PCC recruited families and had them help in the renovations of the site that was located and arranged for during the planning period. In this way some services to families were implemented even though the facility was not usable for children until repairs were completed.

Recruitment of Families

Of the nine centers that had recruited most of their families during the planning period, seven were able to implement programs within the first seven months after funding. On the other hand, only five of the 24 that had not recruited families prior to release of the operating grant were able to begin in a like period.

It should be pointed out that these variables are not independent of one another. In most rural areas, facilities are easier to locate than in congested urban slums. Although widely dispersed, families in rural areas are in many ways easier to recruit to programs if only because these programs are more scarce than in urban areas, where families can shop and pick programs that most meet their needs. Further, the NSP programs were only developed in large cities, and programs funded through these auspices were among the last to initiate services. The organizational arrangements in the cities were incredibly more difficult and complex, with the results that the big city programs have been serving families for the shortest periods of time. The length of time that service to families and children were provided by each of the 35 funded centers is shown on Graph 2. The number of months of service to families ranges from 17 months in two centers down to zero for the two centers not yet serving families. The average number of months of service to children and families is 12.1 months.

Even though the recruitment of families during the planning period helped to reduce the delay in time between release of the operating grant and implementation of services, those centers that



GRAPH 2:

NUMBER OF MONTHS SERVICE TO CHILDREN AND FAMILIES OF 36 PARENT-CHILD CENTERS (as of December, 1969) did recruit families during the planning period faced other problems. By the time funds were actually released, a number of target area parents initially recruited to the planning committees were no longer eligible for the program because their youngest child had long since passed the age of three. Understandably, many of the parents were no longer interested in serving on the Policy Advisory Committee when they were not eligible for services and a few became hostile to the program when their raised expectations were unfulfilled. Though it was thought that the planning committee would evolve rather smoothly into the PCC Policy Advisory Committee, this transition proved to be difficult due to the long delays in funding. Most centers had to develop parent involvement almost from scratch once they were funded.

THE PARENT-CHILD CENTER ORGANIZATIONAL STRUCTURE

Common Administrative Structure

A common administrative structure is indicated graphically in Figure 1. There are, however, exceptions to this organizational arrangement which are discussed later.

It is evident that this organizational structure is multilayered and fraught with possibilities for delays and conflicts. These possibilities were enhanced by a lack of clarity in various regulations dealing with organizational matters. For instance, the criteria[1] established for the PCC state:

> ...the Planning Committee is expected to evolve into a permanent policy advisory committee with at least 50 percent of its membership drawn from parents and other neighborhood residents. For most purposes, this policy advisory committee will be the principal source of judgment on the program of the PCC. As

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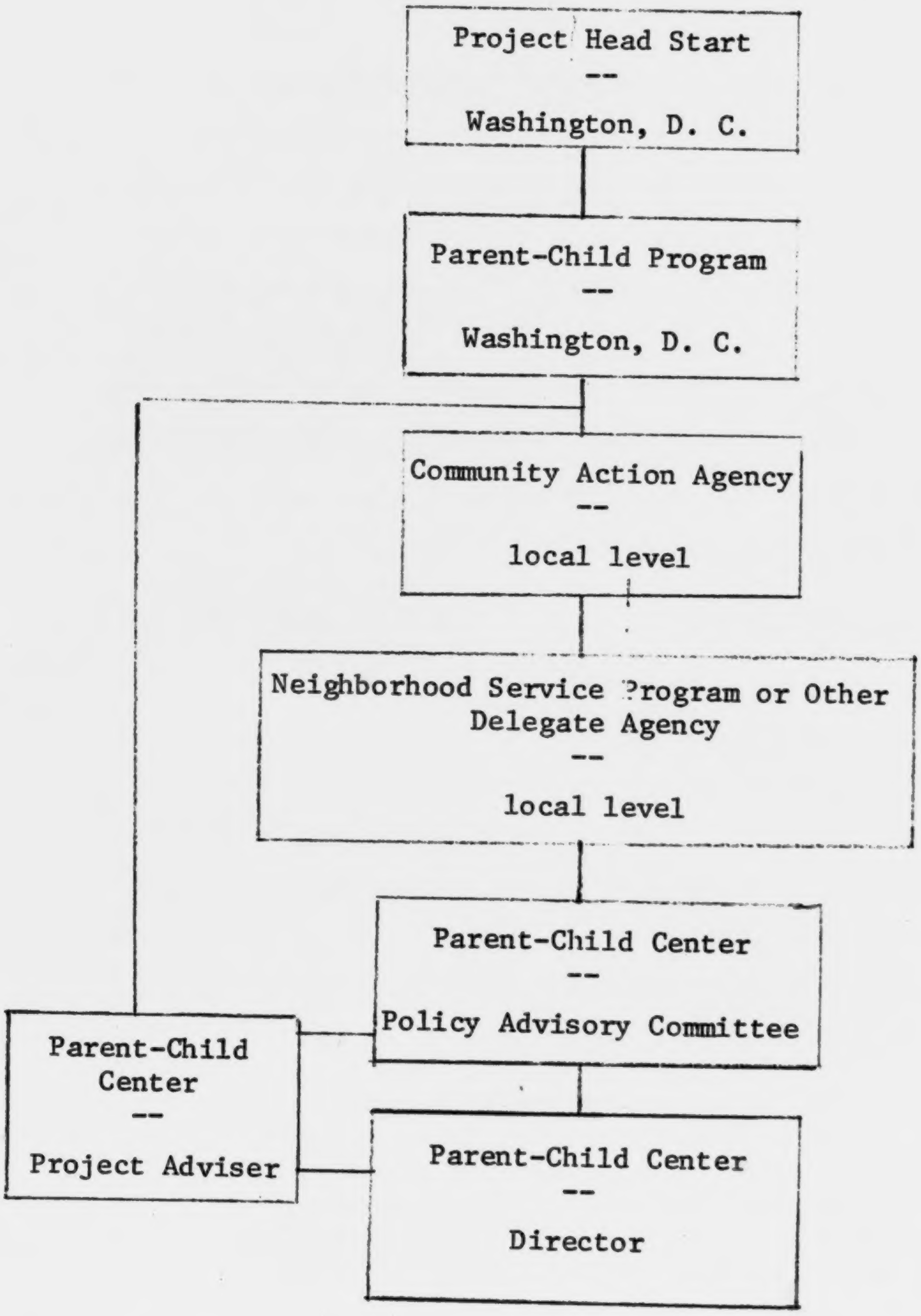
[1] Office of Economic Opportunity, op. cit., p. 9.

FIGURE 1

PCC Administrative Structure


Project Head Start -- Washington, D. C.
Parent-Child Program -- Washington, D. C.
Community Action Agency -- local level
Neighborhood Service Program or Other Delegate Agency -- local level
Parent-Child Center -- Policy Advisory Committee
Parent-Child Center -- Project Adviser
Parent-Child Center -- Director

> indicated in Section M, however, both the neighborhood center and the community action agency have certain authority in matters of importance to them.

and section M[1] states that:

> The CAA will be the applicant agency unless there are compelling reasons to the contrary. However, the PCC-PAC should develop and approve the application prior to submission by the CAA. The Neighborhood Center must be consulted in the development of the application. There must be agreement between the CAA and the PCC on any changes in the application. In those cases where differences between the PCC-PAC and the Neighborhood Center or CAA cannot be resolved, OEO will use its good offices in an attempt to resolve the differences.

and

> To the maximum extent feasible, the PCC shall use the same personnel policies and systems for hiring as are used by the Neighborhood Center. However, all selections will be made by the PCC. Selection of the Program Director shall be made by the PCC-PAC after consultation with Neighborhood Centers and the CAA.

How the organizational arrangements worked out in the early stages is indicated below. It is not surprising, however, that difficulties were encountered in view of the organizational complexities imposed on this small program.

Policy Advisory Committees

The Policy Advisory Committee of the Parent-Child Center (PCC-PAC) was designated in the criteria as the major link in the decision-making process between the parents to be served and the funding source. A few centers were able to make a smooth transition between the planning committee and the PAC, but this was more unusual than usual. Due to the long delays in funding for most centers, the planning committee dissolved and there was no ongoing staff to hold parents and professionals together. It was not until many months after funding and employment of the director that a viable PAC was constituted. By December of 1969, all but three of the 35 PCC's funded had established permanent PAC's, but not all were functioning at the same level of activity.

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[1] Office of Economic Opportunity, op. cit., pp. 11-12.

Most centers have met the formal guidelines specified for the PAC's in that they have established a committee with half of the members parents, and that the PAC "aides and advises" on various program, personnel, and administrative matters as well as in the selection of clients. The information reported by PCC directors on the number of Committee members, the method of selection, the frequency of meetings and the areas of decision-making is shown in Table 3.

Although a total of 32 Parent-Child Centers had established a permanent PAC, these bodies functioned in various ways and with differences in authority, autonomy, and activity, and have been grouped in the following way:

Level of Activity	Number of Centers
Not yet active, seldom meets, or does not have decision-making power	7
Meets regularly, but decisions dominated by professionals	4
Active, meets regularly, participation of the parents growing	8
Active, meets regularly, parents take active part in making major decisions	11
Not enough information available	2
	32

TABLE 3

Parent-Child Centers' Policy Advisory Committees
(31 Centers Reporting)

	Percent
Does PCC have a Policy Advisory Committee	
Yes	90
No	10
Average Number of Members on PAC	22
Range: 10-40	
Proportion of Members who are Parents*	48%-85%
Method of Selection of PAC Members	
All members elected	51
All members appointed	16
Parents elected, professionals appointed	13
Parents and professionals volunteer	10
No PAC	10
Frequency of PAC Meetings	
Monthly	58
Biweekly	19
Weekly	7
When Needed	7
None	9
Final Decision Making Power rests with:	
Policy Advisory Committee	43
Delegate Agency, NSP or CAA	57
Policy Advisory Committee Aides in the Following (by Number of Centers reporting in each category)	
A. Selection of:	
1. Paid professional staff	86
2. Nonprofessional staff	64
3. Consultants	46
4. Other	7.1

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* In two of the centers, all parents serve on the PAC.

TABLE 3 (Continued)

	Percent
B. Project Administration:	
1. Determination of time and leave regulations	36
2. Preparation or approval of budget	68
3. Signing payment checks	14
4. Raising funds	39
5. Conducting grant negotiations	32
6. Other	7
C. Program Planning:	
1. Plan or approve program proposal	96
2. Determine scope of parent programs	82
3. Supervise day-to-day child program operations	36
4. Other	14
D. Interagency relations	64
E. Recruiting client population	64
F. Selection of clients to be served	75

Examples of the first type of Policy Advisory Committees reported by our field staff are:

> The Policy Advisory Committee met only once, and the purpose was to rubber-stamp the refunding proposal. It was pointed out to the mothers that unless this was done, there would be no funds available to continue the program for the next year.
>
> The Policy Advisory Committee is not active, has no authority or autonomy to hire staff....A basic problem according to the director of the center is that community members of the PAC need training in order to function effectively in decision making, in what he called board behavior, in communications, in learning how to take responsibility, and how to follow through after decisions have been made.

> The Policy Advisory Committee met twice and has not been called again because this center has been retained by OEO and the director is not sure whether they need to continue the PAC. Given the research orientation of this program, it has been difficult for the university to work with a Policy Advisory Committee.
>
> The PAC group of the Parent-Child Center has been largely a nominal, though not necessarily an inactive body...the PAC group acts as a kind of social arrangements committee for family parties, etc.

Four of the PCC's have PAC's which meet regularly, but are dominated by professionals of the PCC or some other agency. Examples of this category are:

> the authority of the PAC appears to be limited to concurrence in issues presented by the director. The new supervisor reports that the PAC does not have final decision-making power on program matters, fiscal matters, or personnel selection. It does have "advisory" powers on personnel practices, but does not actually select any personnel. All staff have been "introduced" to the PAC.
>
> though the chairman of the PAC is a mother, and the PAC has the authority to approve programs and hire staff, the search for staff is done by the center staff...they seem, for the most part, to follow the leadership of the center director, and as yet, they have not asserted themselves in an independent way.

Examples of the eight PCC's with active Policy Advisory Committees in which the participation of the parents is growing, are described by our field staff, as follows:

> The PAC, of course, took up its work in the wake of the original PCC Planning Committee. Initially, however, it was not able to sustain a high level of member participation and project involvement. Attendance at PAC meetings was poor, and the group was quite content to leave the program entirely in the hands of the PCC director and his staff. When the time came to prepare the proposal for the continuation grant, the PAC seemed to have come to life again as a major force in the

program. Credit for this rejuvenation must go to the PCC director, who was most concerned that a cooperative program review and future planning process be undertaken as the program entered its second year. The momentum picked up at this point has been sustained, and it can be expected that the end of this program year will see the PCC come under the immediate direction of an active PAC.

It has been difficult to hold professionals on the PAC of this PCC because of the distances required for them to travel to attend meetings...rather than proving to be a significant hardship, this was probably a blessing in disguise. Staff and mothers meet in a setting conducive to significant development by the mothers of social and organizational skills.

The Policy Advisory Committee of the PCC was drawn by democratic processes from the project's planning committee. Initial membership was nine parents and nine professionals from the community. Because the program was in its formative period with much to be discussed and planned, the PAC met every two weeks. During this early period, the parent members were hesitant about taking a full part in the Committee's various discussions. This concerned the professional members, leading them to take patient, positive steps to convince the parents that their ideas were not only welcome but essential for the success of the program. Gradually parent participation increased until it became as full and free as could be desired. PAC meetings are now held on the first Monday of each month, with several subcommittees meeting between times to formulate plans and policies for full PAC approval.

The chairman of the PAC was a professional, with one of the fathers serving as vice-chairman. During the course of the first program year, the vice-chairman has conducted PAC meetings in the absence of the chairman. In this capacity, he has demonstrated excellent leadership qualities and he must be credited with motivating other fathers to attend the PAC meetings and convincing them that their voice really counts. This father is also chairman of the Renovations Committee and serves on several other committees.

From the outset the PAC set out with the determination to be the moving force behind the PCC program.

> In this spirit they moved to modify program eligibility requirements restricting membership to families with four or less children. The PAC removed this restriction when it was found to be keeping out several families anxious to join the program. At one meeting a non-PAC member parent was upset when he learned that he could take part in the discussion of a policy but not vote on it. Out of sympathy with the need to make the PCC a family-oriented program, the PAC decided to open its membership to all PCC parents. The PAC has been operating with this broadened base since April of 1969.

The largest number of PCC's, eleven, have active Policy Advisory Committees in which the parents take an active part in the decision-making process of the Committee and for the center. Examples described by our field staff include:

> From the beginning the Policy Advisory Committee was given a free hand to guide and direct the program. The PAC was set up in accordance with national guidelines, and contained many carryover members from the original planning group. Meetings were well attended and conducted along parliamentary and democratic lines ....Because of the persistent and encouraging efforts of the professional staff and PAC members, parent members of the PAC have accepted the invitation to take a full and active part in PAC deliberations.
>
> At first the PAC functioned as a "rubber stamp" for the director's ideas and rapidly fell into disuse. Recently it has revitalized itself and now serves not in an advisory capacity but in a policy-making role. At times it has taken administrative action in opposition to the director....This PAC is operating without bylaws and without ever really having defined what its function and authority is.
>
> The existing PAC is responsible for the hiring and firing of the PCC staff and for making almost every decision for the PCC.
>
> The PAC constituted by federal policy is active and initially met every week when first elected in March of 1969. The group perceives itself not as an advisory committee but as the "Board" of the PCC. Of greater significance, it views its role as that of policy and decision-making body with autonomous power.

Thus, while 32 of the Parent-Child Centers have established Policy Advisory Committees in keeping with the federal guidelines, these PAC's are operating at several different activity levels and with differing interpretations of their responsibilities.

Factors Related to Decision Making Within the Parent-Child Center

The major role in making decisions about the policies of the Parent-Child Centers may be taken by one of two groups within the PCC: by the staff or by the parents on the Policy Advisory Committee. PCC policy may also be established external to the PCC: by the Community Action Agency or the delegate agency. By the end of 1969, of the 35 funded PCC's, four were directed from outside of the agency--one by the delegate agency and three by the Community Action Agencies. The 11 PCC's in which the parents take an active part in the decision-making process, as previously described, are termed "parent-directed." The other 20 are termed "staff-directed."

Whether or not parents participated in the decision-making process of the agency seemed to be very much related to the educational background of the PCC director and to the size of the Policy Advisory Committee. Whether or not the parents are active in the decision-making process is crucial in determining the kind of services provided.

Degree of Director: As already described, the PCC directors were almost always employed prior to the establishment of the Policy Advisory Committee, and in fact were largely responsible for its development. As Table 4 indicates, seven of the 11 PCC directors with a degree in education established Policy Advisory Committees on which the parents had major decision-making responsibility, but no directors with degrees in the social sciences and only one with a degree in social work did.

TABLE 4

Relation of Background of PCC Director to Decision Making in Policy Advisory Committee

Background of Director	N	Source of Major Decision Making		
		Staff	Parents	Outside PCC
Education	11	3	7	1
Social Work	7	5	1	1
Social Science	8	8	0	0
Other	3	1	1	1
None	4	1	2	1
DNA	2	2		
	35	20	11	4

Size of the Policy Advisory Committee: As might be expected, parents were more likely to have a role in the decision-making process of the Policy Advisory Committee when there were fewer members on the committee. The average number of PAC members reported for all PCC's is 22 and the number of committee members ranges up to 40. However, of the 11 PAC's that were parent-directed, eight had fewer than 20 members. It is only logical that parents unfamiliar with board behavior and inexperienced in making policy decisions will find it easier to function in small rather than large groups.

Type of Children's Program: Of the ten Parent-Child Centers which provided day care either within the center or in group care homes, six were parent-directed, three were staff-directed and one was community-directed. It would certainly appear that when parents have an active role in making decisions about the kinds of programs implemented to meet their needs, most will choose day care.

There seemed to be no relation between the degree of decision making by the parents and the number of months of service by the

PCC. Nor did it seem to bear any relationship to either the ethnicity of the director, the staff, or the enrolled families or to the location (rural or urban) of the PCC. The two important factors in determining the extent to which parents participate in the decision making of the PCC appear to be the size of the committee and the educational background of the director.

Comments about PCC Organizational Arrangements

Because the guidelines delegate authority to the PCC-PAC "after consultation with the neighborhood centers and the CAA," the PCC's have encountered many frustrations in their attempt to exercise the authority delegated, particularly in the selection of the program director. As one field research associate who evaluated four different PCC sites has commented:

> Somehow I have the feeling that the planners of the PCC program did not think through carefully enough the pattern of relationships that needed to be shaped between CAA's and PCC's. The idea of making the PAC the board of responsible accountability may have sounded good initially, but considering the fact that in some localities this board would be some time in achieving a composition that would be stable and responsible, it seems understandable that the CAA would be apprehensive about giving it carte blanche in the disbursement of funds.

The guidelines as written assume first that there would be a stable, fiscally responsible PAC; second, that the CAA would be willing to relinquish to the PCC-PAC functions and powers it normally retains in other programs funded through OEO; and third, that OEO would be able to use its "good offices" to resolve any differences.

The first assumption--that a stable PAC could be developed in time to select the director--just did not occur. Most Parent-Child Centers did not have an operating Policy Advisory Committee until many months after the first director had been approved. In some cases the planning director became the permanent PCC project director, but in most cases the long delay in funding as well as other factors meant that the planning director left the PCC and a permanent director was selected by the CAA, the delegate agency, or the NSP. Most PCC directors found themselves having to develop parent involvement and a PAC after they were hired. By the end of 1969, three PCC's still did not have permanent Policy Advisory Committees, and at one of these centers even the second PCC director had been employed by the delegate agency director while permanent members of the PAC were still being selected. What the established criteria failed to recognize was the length of time required to recruit program recipients onto a board and train them to be able to make responsible fiscal, personnel, and policy decisions.

As it turned out in practice, the assumption that CAA's, the delegate agencies, and their directors would relinquish controls frequently did not happen as one field researcher writes:

> The question of just who has authority over the Parent-Child Centers project has been a source of contention since the project's inception.
>
> The PCC operation grant states that the Policy Advisory Committees shall be responsible for approving programs and selecting staff members, as well as for making policies. The document was signed and approved by the CAA board and executive director. It appears, however, that the board and director are not willing to live up to their contractual responsibilities, but instead are pressuring the PCC's for project funds and increased control over project activities and staff selection.

With this PCC as with others, a power vacuum existed when the program was first funded and no fiscally responsible group was available to make decisions, select staff, and expend funds. As the fledgling PAC's struggled to develop, the power vacuum was often filled by the NSP, the delegate agency, or sometimes by the CAA itself. Once these other groups assumed the powers and prerogatives of the PAC, they proved reluctant to relinquish them.

Conflict over control has centered in three areas: (1) selection of staff, (2) the requirement of prior approval of the CAA or delegate agencies for all purchases and expenditures, and (3) payment for medical and dental services provided PCC families.

That selection of staff should be a major area for power struggles is to be expected since any neighborhood organization, be it a political party, the CAA, the NSP, or the PCC has the distribution of jobs as its most important organizational tool. Since the CAA's or the NSP's filled the positions of directors in the absence of an active PAC, it is to be expected that they would attempt to retain this prerogative and select other staff, as reported by one of our field researchers:

> The PCC wants to employ a trainer in the field of infant education, but the CAA wants the trainer to be available to train in all CAA components. The [Neighborhood Organization] wants the right to fill all PCC jobs with its people, while the PCC wants to employ people qualified to work with infants.

Fiscal control by the CAA is the implement by which the PCC can be manipulated into conformity. In some PCC's this fiscal control is so tight that any purchase over $1.00 must have prior written authorization. When this control is applied to medical bills it causes great difficulty for the PCC, since babies do not wait for "prior authorization" to get sick. At two PCC's the CAA has refused to pay medical and drug bills incurred without authorization.

Either the regional or national office of OEO has been called upon in several cases to resolve disputes and has done so effectively in the smaller communities, sometimes through negotiations with all concerned parties, or in one case by withdrawing funds from the CAA and funding the PCC through a college instead. In larger communities, particularly big cities, Head Start apparently has not been able to intervene successfully in local power struggles despite the "good offices" promise in the guidelines.

In summarizing his experiences with the organizational structure and development of the PCC's, one of our field research associates who observed a number of centers writes:

> My basic impression about most of the problems afflicting the CAA-PCC situation is that the fundamental difficulty stems from the impression PCC directors were given about the independence of their programs from the local CAA's in which they operate. Somehow they were given the impression that the PCC's were to be accountable only to their own PAC's. The CAA was to treat them as autonomous agencies, affiliated with the CAA only in terms of fiscal convenience. Some CAA's, however, chose to see the PCC as a program account for which they were the basic accountable agency. In their mind this meant that PCC was to be operated under their control and supervision. They expected to see this attitude reflected in their relations with the PCC director and staff. When the PCC treated them as bookkeepers and very remote affiliates, the usual bureaucratic games of delay, suspicion, and conflict began.
>
> With respect to the four centers I have been covering, I would say that only one director wisely sensed the importance of working in a subordinate position to the CAA. As a result, he now enjoys the ability to have contested decisions decided in favor of the PAC position. For example, he was successful in preventing the CAA from moving the PCC into the Neighborhood Services Center.
>
> It seems likely that if the PCC staff had showed a reasonable amount of surface deference to the CAA at the outset, they would soon have found that most of their recommendations to the CAA would have been honored, giving them in effect all the internal control they would need to conduct their program as they saw fit. It is hardly likely that the CAA would find time or interest in monitoring the PCC at close range, especially if the program gave evidence of positive achievement.

Other PCC directors have found it expedient to shift their strategy from confrontation with the NSP or CAA to one of conciliation and cooperation. Federal guidelines and criteria notwithstanding, it has proved difficult for local communities to implement their programs without working with the CAA's, the NSP's, or delegate agencies. In order to do this, many PCC's have had to relinquish some of the decision-making powers promised in the federal guidelines.

SUMMARY AND RECOMMENDATIONS

Summary

Any consideration of the programs developed by the Parent-Child Centers must be prefaced with a recognition of the many handicaps under which the centers developed. They began with a set of objectives almost global in scope, in communities lacking many of the conditions and services essential to support the objectives specified. After a six-month planning period, the 25 urban and 11 rural communities submitted proposals for a $175,000 federal grant to be matched with a 20 percent local contribution.

Badly understaffed on the national level, the organizational structure was unwieldy, the guidelines unclear and conflicting. Of the 35 centers funded, grants were made to two state OEO's, one Title III migrant grantee, to the CAA's and their delegate agencies including three universities, two long-established social work agencies, and 13 Neighborhood Service Programs. Delays in release of the operating grants and delays in implementation of services to children and families were prolonged in many cases. Those centers that were able to implement services to families in the shortest time period after funding were the centers in rural areas, those funded through new structures developed to administer the Parent-Child Centers, and those that had located facilities and recruited families prior to submission of the proposal.

Delegation of authority to the PCC was often contested by the CAA's or the delegate agencies, in part because of delays in the development of fiscally responsible Policy Advisory Committees for the PCC's, but mainly because of a lack of clarity in the guidelines. Authority previously delegated to the CAA was now delegated to the PCC's. By the end of 1969, 32 of the PCC's had activated Policy Advisory Committees which functioned at various levels of activity and autonomy. Those 11 Policy Advisory Committees on which parents were active in setting policy made decisions that had important program implications. Most of the day-care programs developed in the PCC's were at centers which were parent-directed.

Much of the report will describe the difficulties and the many creative and adaptive methods used by the PCC's to overcome the handicaps with which the programs began. Given the set of circumstances it can be considered an achievement that within less than three years from the time the program was first suggested, 35 of the 36 centers planned have become viable organizations.

Recommendations

In the light of the experiences and the accommodations made by the Parent-Child Centers during the period of development, the following recommendations for planning and funding are made:

1. Communities selected for pilot or demonstration projects should have a level of resources consistent with the design and goals of the demonstration program.
2. Target neighborhoods selected should have sufficient eligible families to sustain expected enrollment.
3. Families recruited during the planning period should have a child under two (rather than three) so that they remain eligible for services after the program is funded.
4. The planning period in big cities should be extended to one year to allow for the additional organizational complexities and problems encountered.
5. The organizational hierarchy from Washington to clientele should be simplified, especially in the case of small demonstration projects such as PCC.

6. Delegation of authority and power should be made clearer and more explicit in regulations and administration of programs should be consistent with these regulations.

7. Organizational arrangements should be made to cover the period that seems inevitable between development of plans and their funding so that a smooth transition is made to the operating phase.

CHAPTER IV

THE PHYSICAL FACILITIES

INTRODUCTION

The comprehensive program envisioned for the Parent-Child Centers requires a facility that is large, varied, and flexible. Although all services do not have to be provided within one facility, even the coordination of a variety of programs for parents and children of different ages requires considerable space. In addition, the centers were expected to meet the guidelines established:

> The Center may be housed physically in one large building or a cluster. The building must offer physical comfort to those who come, such as attractive waiting rooms, provisions for the activity of children who wait with their parents, and the like. The facilities should demonstrate respect for the people who come there by their good condition, style, and aesthetic quality.[1]

Further, the criteria specified, "It is assumed that all programs will initially operate in space which is available as a non-federal contribution, or on a rental basis....OEO will provide limited renovation funds within the cost limits specified above for approved program." Perhaps no set of directives proved more difficult to accomplish for the PCC's, and certainly the location of the physical facility consumed more staff time during the first six months of program funding than any other task. The effect of location and renovation of the physical facility on the length of time required to implement services is described in the chapter on Organizational Development.

The location of the facility, the type of facility leased or donated, the amount and arrangement of the space all have a major effect on the kind of services implemented. Because of delays in refurbishing the facility, most PCC's developed their programs in two phases. The first phase consisted of work with the parents in the homes and continued until the second phase of center services to children and parents could be implemented. Code restrictions in all urban and many rural areas set strict requirements about the types of facilities appropriate for the group care of infants and toddlers. Until at least many of these requirements could be met, center services for children were not possible and, as many staff soon discovered, the homes of the PCC children were rarely conducive to implementing enrichment or exploratory activities for any but the youngest infants. For some PCC staff there was a hiatus of from three to six months between the end of preservice training and the implementation of services to families. That morale problems were not even more severe while the staff awaited the completion of building improvements is a tribute to the enthusiasm of many of the directors.

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[1] Parent and Child Centers, A Guide for the Development of Parent and Child Centers, OEO Pamphlet 6108-11, March 1969, p. 9.

The space required to implement the comprehensive services specified for the PCC's is extensive. Space to meet the varied needs of infants, toddlers, three-year-old runabouts, older siblings, and adult family members must be large, separated, and differently equipped. The space needs of a PCC are quite different from the more homogeneous needs of the four- and five-year-olds in Head Start. Young infants require a quiet place in which to sleep at various intervals during the day. They also need playpen space for waking hours, and some area where they can observe the activities of older siblings and other people. Toddlers need space for their eager explorations that can be separate from the areas needed by truck and tricycle riding three-year-olds, or ball-playing eight-year-old siblings. Parents need space in which to meet for classes, group discussions, cooking, sewing, or sociable activities.

THE FACILITIES DEVELOPED

The facilities that house the PCC's vary both in their prior use and in their adequacy for present purposes. The 35 operating PCC's have opened a total of 58 separate sites from which to provide services. The rural centers have opened a total of 32 sites to serve their widespread client population. Only two of the urban PCC's have more than one site, but two rural PCC's have five separate sites each.

The buildings most likely to be converted for use as PCC's in both rural and urban areas are former private residences, followed by unused or abandoned public schools in the rural areas, and church Sunday School or basement rooms in both rural and urban areas. Commercial buildings, former stores, or in one case a former bar were also utilized. The types of buildings in which the 58 sites of the PCC's were housed are shown in Table 5.

TABLE 5

Prior Use of Parent-Child Center Facilities

Type of Building	Number of Sites	
	Rural	Urban
Church	5	3
School	7	1
Private Residence	17	9
Private Apartment	0	2
Public Housing Apartment	0	2
Commercial Buildings	3	4
NSP Facility	0	1
University	0	2
Temporary Facility		2
	32	26

Residences

Seventeen of the rural and nine of the urban sites of the Parent-Child Centers were formerly residences. One such site in a large urban area is described by the field associate:

> The building in which the present center is housed is a large, brick two-story dwelling, with a basement and an attic. The house appears to be quite worn on the outside. The bricks are quite dirty, many of them chipped, and the large front porch with its old-styled banister and wooden columns is in serious need of painting. The lawn in the front yard is rather neatly landscaped, with two very huge trees being almost two feet away from the iron fence and gate that separates the lawn from the sidewalk....[On entering] one immediately notes the contrast of the oldness of the house on the outside and the brightness and warmth that it has on the inside.
>
> What was formerly the living room has been converted to a lounge for the parents and visitors. The dining room serves as the play area for toddlers. It is equipped with rocking horses, an easel equipped with art paper, and the usual Head Start type toys. What must have been the library is now a nursery with three cribs over which hang mobiles. At the back of the house is the kitchen. It is equipped with a regular refrigerator and stove, but since...snacks and lunch [are served] only to about four or five toddlers a day this is adequate.
>
> On the second floor are the offices of the director, the nurse, and the teacher. A fourth large room is attractively furnished with a large table and several pastel vinyl chairs. This serves as a lounge for the neighborhood workers. The attic and basement are used for storage. One real limitation of the center is that there is only one bathroom in the building. I think this house is very functional for the purposes of the Parent-Child Center.

Not all old residences have as much potential for use by a Parent-Child Center, however. An example of a rural center that developed two widely separated sites, neither of which is really adequate, is described by our field associate:

> A great deal of difficulty was experienced in finding suitable rental facilities in both communities. Eventually two structures were found that could be renovated and used for the centers. Neither, however, provides sufficient space for program activities for more than a few children at a time. The home improvement aides did an amazingly good job of making the two buildings attractive and usable, but could do little with the space problem.
>
> One center has outside play space that, although sloping, can be used by the older children in good weather. The other center has lost some of its planned outdoor play space due to infringement by the owner. This is presently being negotiated. If the negotiations are successful and a planned safety fence is built next to the ravine and the river, it will also have outdoor play space for the children.

Another associate reports:

> Both centers need carpets for the infants to crawl on. The infants in many parts of this area are kept in their cribs much of the time and not permitted to crawl because of a lack of carpets and the generally poor condition of the floors at home...they should have the opportunity to crawl on the floors at the center....
>
> One center still lacks adequate water, but plans are being discussed for solving this problem. Heating is a problem in both centers. They are both heated by unvented gas heaters which are dangerous. The women tend to keep these facilities grossly overheated, possibly as compensation for the lack of adequate heating in their own homes. They are stuffy to the point of discomfort.

One rural center that was fortunate in finding two large residences from which to operate is described by one of our observers:

> These large, two-story residences are surrounded by spacious yards which provide ideal outdoor play areas. The buildings have undergone extensive renovation since the program's inception in September 1968, some 16 months prior to this writing. Now they are

> attractive facilities, very appropriately arranged, and well-equipped for their various purposes. Much of the renovation work has been done by the staff and parents and community volunteers. Much of the equipment and many furnishings have been donated or purchased at reduced prices.
>
> The centers are attractive, charming, and comfortable, but in addition to these attributes they are functional as well. There are appropriate places for every activity and for every age group.

For the most part, these old houses have been transformed from run-down and drab places to cheerful facilities. Where PCC's have been fortunate enough to find large houses, they provide adequate space for a variety of activities.

Schools

While most of the eight schools now in use for PCC services are quite adequate, they have required extensive repairs since nearly all have long been condemned for use by school-age children. The results of the renovation of this kind of facility are described by one of our field staff:

> Before it could be used by the PCC program, this wing of the school had to undergo extensive renovations, including electrical rewiring, floor covering, painting, plumbing, office partitioning, and cabinet installation. The results have been impressive. The center now houses an attractive nursery, a comfortable mothers' lounge, a well-equipped demonstration kitchen, and staff office space. Being a carpet mill center, the citizens have seen to it that their PCC is luxuriously carpeted throughout. The main entrance room has been partitioned into two private staff offices and a general office. All spaces have been furnished by the PCC, with parents and volunteers taking an active part in the selection of furniture and equipment. These once barren rooms have been magically transformed into a warm, comfortable site for families and staff to carry out the purposes of the PCC project.

Though in many ways very attractive and comfortable, the facility has some handicaps as described below:

> The facility does have some inherent drawbacks. Space is at a premium. The staff could definitely use more office space; the kitchen is too small to accommodate the washers and driers, sewing machines, kitchen equipment, as well as the cabinets used for the storage of foodstuffs and homemaking materials. The mothers' lounge has to do double duty as the sleeping room for infants, and the nursery is handicapped by not having a convenient outdoor play area. The children are allowed to play outdoors on the school grounds, but as a shared space the PCC has been unable to set up the outdoor equipment acquired for a children's playground.

Even though there are limitations, these old schools, once renovated, almost always make excellent facilities for PCC programs. They usually have a number of large rooms, a kitchen, some undivided, multi-purpose space as well as an adequate outdoor, fenced play area. The floor plan of one of these renovated schools is shown on Figure 2. The rich program that can be developed in such space is described by one of our reporters:

> The starkness of last winter is now a faded memory as the PCC staff and families meet, work, study, and play in the abandoned schoolhouse they have turned into a bustling center of warm hospitality and cheery companionship. One classroom has been turned into a well-equipped nursery, with another serving sleeping infants and toddlers. The third classroom has been partitioned off to make room for a demonstration kitchen and a parents' lounge. The mothers use the lounge for sewing on the center's machines and for their classes and meetings. Outdoors, the rear of the center has been fenced in for a play area. The PCC has acquired a number of junglegyms and other outdoor play equipment, as well as pouring a concrete tricycle pathway. Weeds and shrubs have been cleared from the front to allow off-street parking.
>
> The school bathroom was a rather large space originally and this has allowed the PCC program to partition the room in such a way that they not only have two bathrooms (double sinks and toilets) but a large room for the center's washer and drier.

Renovation--

1. Sinks and toilets in each room (in coatroom)
2. Radiators covered
3. Floors tiled
4. Exit from play area
5. Refencing play area and parking

Comments--

1. Children must walk up about 10 steps to first floor.
2. There are entrances to the play area from the basement.
3. Room #3 has partial renovation done.
4. Staff bathrooms are located between the first and second floors
5. Additional offices (5) on second floor above Room #3.

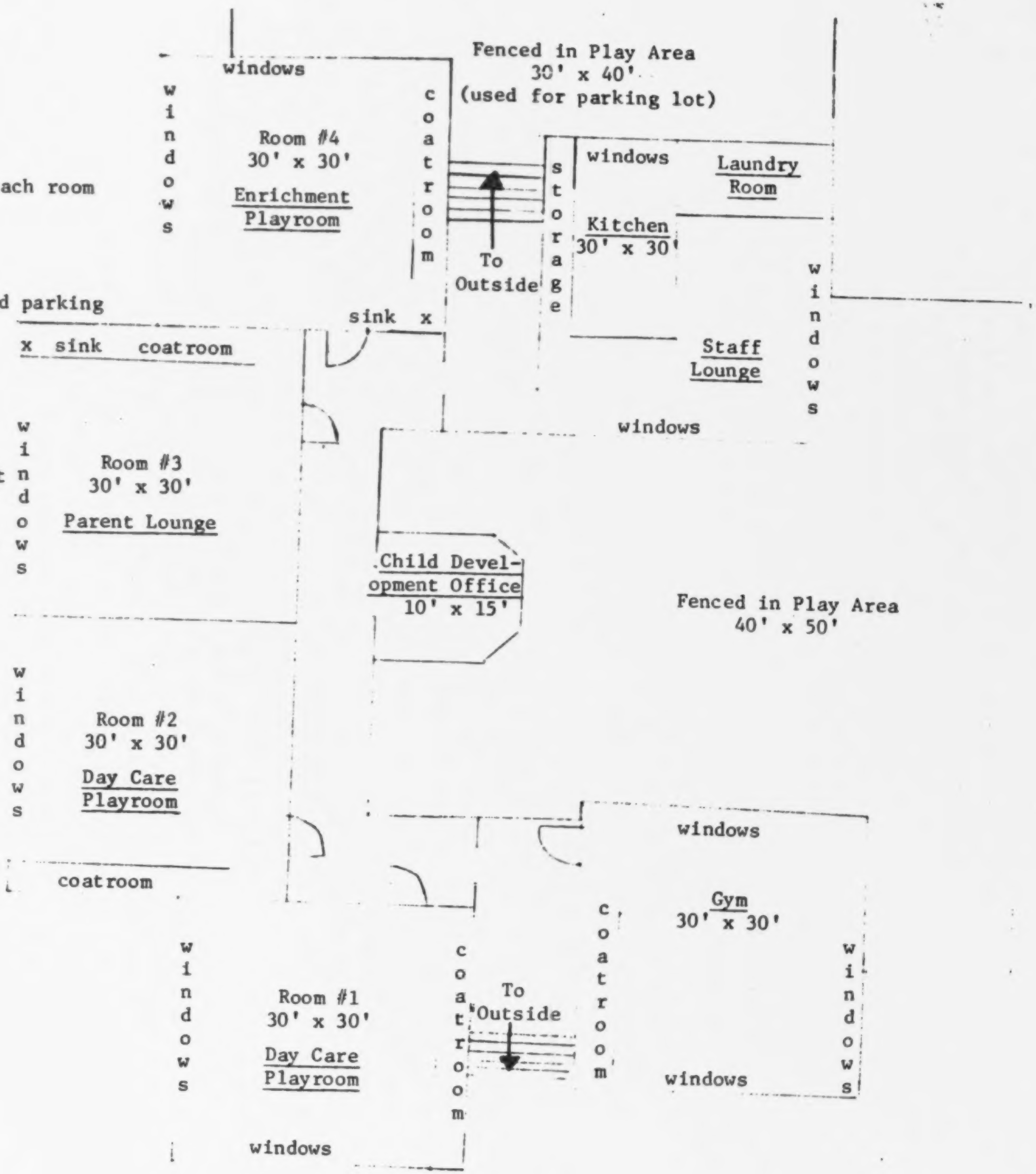
Fenced in Play Area
30' x 40'
(used for parking lot)
windows
windows
Room #4
30' x 30'
Enrichment Playroom
coatroom
To Outside
storage
windows
Kitchen
30' x 30'
Laundry Room
Staff Lounge
windows
windows
sink x
x sink coatroom
windows
Room #3
30' x 30'
Parent Lounge
Child Development Office
10' x 15'
Fenced in Play Area
40' x 50'
windows
Room #2
30' x 30'
Day Care Playroom
coatroom
windows
Gym
30' x 30'
coatroom
windows
windows
windows
Room #1
30' x 30'
Day Care Playroom
coatroom
To Outside
windows

FIGURE 2: Floor Plan

Churches

Five rural PCC's and three urban ones utilized church facilities for their PCC's. In many cases, the Sunday School rooms are quite easily adapted for playrooms for toddlers. One such facility, within a short walk from the housing project where most of the families live, is described as:

> The center has a very fine permanent location in the basement of an Episcopal Church from whom they are renting the entire lower hall (see attached Physical Facilities Report). The four rooms used for the sleeping and playing of children are neat, clean, and attractively decorated with a variety of pictures (families, animals, clowns, etc.). Each room also has a great number of toys and play equipment--they are clearly rooms for children.

This particular church facility is large enough to provide space for day care of about 20 children.

Several commercial buildings including a garage, a paint store, and former bar have been renovated to provide PCC space. One such that was remodeled to allow for full-time day care of about 30 children is described by our field visitor: "The center is generally a fun, nice place to be. It is cozy inside, cheerful, and well laid out." Another that provides for a variety of programs but is pressed for space is described as follows:

> The offices of the staff members are large and roomy. The two playrooms are adequate in size for a group of about eight children. The kitchen in which the meals are prepared is adequately equipped, but due to poor planning, it was placed between the two playrooms with no independent access. The family-life education room is a bit small to accommodate both the mothers and the sewing machines. The center is very well equipped with materials and toys which are both attractive and educationally useful. The outdoor play space is rather small but the center has adequate outdoor play equipment.

IMPLICATIONS OF THE FACILITY ON PROGRAM DEVELOPMENT

When one reviews the difficulties encountered by the PCC's in locating, arranging, and renovating the 58 sites now occupied, the achievements of most of the centers are very impressive. For the most part, dim, dismal, run-down, and frequently condemned buildings were turned into warm, cheerful, and attractive places where a variety of activities could be carried on.

Amount and Allocation of Space

Problems remain at some of the centers, and the lack of space at a number of them is limiting implementation of some activities. About half of the centers have sites that are too crowded or inadequately arranged to provide separate space for infants. Most of the centers have dealt with this lack of space by staggering the times at which infants and toddlers are brought to the centers. This limits the number of hours of contact with the child and the possibility of heterogeneous grouping is precluded. More space might mean more service for many of these centers.

In some centers office space took first priority, but in more programs the service component was allocated the majority of the space. In part this allocation depended upon the focus of the program. Those PCC's that focused on providing social services and counseling for adults allocated more space to offices. About a third of the PCC's have crowded office space. Many of the directors have to share their offices, and many PCC nurses do not have separate rooms in which to examine children or isolate a sick child. As one of our field staff writes:

> Office space is inadequate. The director's office is quite small. The secretary has had to locate in the hallway entrance. Any other staff has to work from desks set up in various corners of the three classrooms.

Another says,

> Where the PCC is presently housed there is inadequate space for either programming or offices. The director shares an office with the assistant director; the supervisory staff share another office and the eight aides share a playroom converted to an office for their use. Children are not brought to this center for there are no available facilities.

Another of our field staff writes:

> It has been a tribute to staff, parents, and children that they have endured in such inadequate, overcrowded quarters with good humor and tolerance.

The importance of having adequate space to implement a variety of programs, as well as to allow the staff who must do the bookkeeping and clerical tasks a place away from infants and toddlers, has been recognized by most of the centers and has in fact consumed much energy and time. The noise of children playing distracts the clerical staff on the one hand, and the sound of the telephone and typewriter awakens sleeping infants on the other. One way in which some of the PCC's have dealt with this is to house the administrative and clerical functions in one apartment or building and the service functions in another. While this has the advantage of separating mutually incompatible needs, it has the disadvantage of removing some of the administrative and supervisory staff from the operating program, with resulting communication gaps.

Outdoor space was limited at three rural and three urban centers. At the urban centers both play space and parking space were limited. At the rural centers, the outdoor play space was more often inadequate rather than nonexistent. At four of the Parent-Child Centers outdoor space was so limited or hazardous that children could not be allowed out to ride wheel toys or play in sandboxes. It is essential that outdoor space used by toddlers be of grass rather than asphalt, although an asphalted path on which to ride a trike or pull a wagon is a useful addition to outdoor play areas.

Proximity to Families

Whether the physical facility is located centrally enough that most or many families are within walking distance is important to program development. As Table 6 shows, only about 20 percent of the centers were so centrally located that almost all the families were in walking distance. Nearly all of these centers were in housing projects and all were in urban areas.

TABLE 6

Families Within Walking Distance of Parent-Child Centers

Proportion of Families	Percent of Centers
Almost all families	20
More than half	11
Less than half	31
Very few	34
No families yet recruited	6

As discussed elsewhere, it is difficult to transport infants and toddlers except for very short distances by any method other than car or bus. Those centers that had very few of their families within walking distance had to allocate considerable staff time to transporting families to the center. Even though the rural centers established an average of three sites each, few of the families could get to these sites without transportation.

The importance of the physical facility location, the amount of space available, the way in which the space is divided and allocated, and the distance of the facility from the families are all important elements in determining the type of program provided.

EQUIPMENT

The Parent-Child Centers need three types of equipment: equipment for children's programs for indoor and outdoor use; equipment for parents' programs, including sewing machines, stoves, and lounge furniture; and equipment for the staff, including desks, typewriters, and other office furniture.

Of the equipment purchased for children's programs, the outdoor play areas were more apt to be equipped appropriately than the indoor nurseries and play areas. Most outdoor areas were equipped with swings, slides, a sandbox, a junglegym, and a variety of wheel toys. The equipment at some centers was described as being both attractive and educationally useful. One site that used a great deal of ingenuity to make the space useful and to develop creative play experiences was described as follows:

> The room was very large and was rather cleverly subdivided (using benches) into fairly distinct areas. There was a large activity area which contained a big paper box used as a garage for parking tricycles (an activity taking place on our arrival). There were large cardboard blocks, a small slide, wooden blocks, farm animals, and foam blocks. Adjoining this area was one containing rocking toys and carts. There was a doll area with stove, sink, ironing board, dolls, and clothing items for "dressing up." Then there was an infant section with a porta-crib, full-sized crib, diaper-changing table, playpen, buggy, bassinette, and rocking chair for adults to hold children and rock with them. This section was the farthest away from the large activity area and hence apt to be quietest of any of the areas.

Another field research associate reports:

> The equipment at this center is excellent. The indoor equipment is from Creative Playthings. The playground

> is also well set up. The parents' lounge has modest but ample furnishings. A very fine small collection of books for very young children is available....Day-care equipment, cribs, high chairs, kitchen and laundry equipment are new and of good quality.

However, of the equipment at another center, the same field observer writes,

> Toys and books in the playrooms and those used in home visiting are generally inappropriate for one- and two-year-olds and most threes....Books are of poor quality. They are not at all adequate for "point and name - name and point" activities with early toddlers and not suitable for reading to older toddlers. Whoever purchased this equipment did not have any real feel for children under three.

The reason for this seems to be, as the same field observer states,

> Few trained personnel seem to know anything about children under three, especially methods of cognitive stimulation and language development.

Another of our field staff also emphasized the need for someone knowledgeable about the development of infants and toddlers to select appropriate equipment. He reports:

> The main equipment obtained by the PCC pertains to the children's play activities. Most of the acquisitions are of the familiar commercial variety requiring large muscle activity and gross motor involvement designed primarily for recreational purposes. Most of the "toys" require individual participation and are not constructed to encourage use by several children.

The equipment at a large number of centers was felt to be more appropriate to Head-Start-age children than to toddlers as described by one field staff:

> The equipment consists of the usual tables and chairs and child-sized kitchen equipment seen in many Head Start classrooms. There are no shelves for toys and nearly all are stacked in plastic milk bins against one wall. A canvas jumpseat and a jumphorse represent the

> two items of equipment for infants or toddlers. It is difficult to find a toy that is both safe and appropriate for a child under a year of age among those stored.

Perhaps the most appropriate comment on the lack of relevance of the equipment at some centers was made by a small boy being visited by an infant educator. He merely packed up her kit of toys and handed it back to her!

Though many of the staff of the PCC's complain about a lack of funds to purchase equipment, it would appear that they are in more urgent need of assistance in making wise selections and appropriate purchases with the funds they already have. Toy-making projects as well as a cardboard carpentry workshop have been set up at several centers so that parents can learn to make toys and equipment for their children. The purchase of new toys for use by their children in the PCC's is an area of great interest and excitement for many of the parents. Because they have never had the opportunity to buy new toys for their children, some are less impressed with making toys and using such familiar objects as pots and pans, key rings and measuring spoons as toys. In part, the inappropriateness of the selection of the toys at some centers is because the mothers were carried away by the pictures in the toy catalogues and made purchases not always entirely appropriate to the age group for whom they are intended. This behavior is not unlike that of middle-class parents who buy Christmas toys as much for themselves as for the children for whom they are supposedly intended.

SUMMARY AND RECOMMENDATIONS

Summary

The problem of locating, renovating, and decorating a facility appropriate for a wide variety of activities for all age levels was difficult for many Parent-Child Centers to solve. In large measure, the physical facility available determines the kind of program that can be provided, the number of activities that can be scheduled simultaneously, and the number of children who can be at the center at any one time. The success of the staff in living through almost intolerable conditions and in converting drab, run-down space into warm, attractive, and functional quarters is most impressive.

A total of 58 separate sites were developed by the 35 operating PCC's, 32 of which were opened by the 11 rural Parent-Child Centers. The largest number of PCC's have utilized residences, followed by schools, churches, and renovated commercial buildings for the PCC's. Some of each type of facility, whether residence, school, or church were very adequate, but a few of each type did not provide enough space to allow for either a full range of activities or a separation of activities. Some of the playrooms for children are on the second floor of residences. This might prove to be a real danger in the event of a fire. Many PCC's tended to lack office space because they had placed the major emphasis on utilizing all available space for service activities. While the equipment for the offices and for the parent activities were generally adequate, many centers need assistance in selecting toys appropriate to the child under three.

During this first year of operation, the staff of nearly all the PCC's have been successful in locating an adequate facility and in effect, changing a sow's ear into a silk purse.

Recommendations

The major recommendations made at this time are:

1. The facility should be located during the planning period, if possible, and funds for its renovation should be released prior to employment of staff.

2. The possibility of developing capital funds to build facilities large enough to provide service to sizable groups of children should be explored.

3. Since rural areas probably will need an average of three sites to serve their widespread clientele, sufficient funds to renovate and equip multiple sites should be allocated.

4. Where health and safety codes are nonexistent or not enforced, PCC's should observe the strictest safety measures to protect the children served. Infants and toddlers should not be grouped in second floor rooms unless there are adequate outside fire escapes, and a staff ratio of one adult for every two children.

5. A list of equipment appropriate for use with children under the age of three should be compiled and supplied to the PCC's.

6. Centers should be urged to acquire facilities with outdoor play space, and funds should be allocated to fence and grass the area.

7. At least one room of the Parent-Child Center should be equipped for infants. This room should be carpeted so that crawlers, swimmers, and wigglers can be put on the floor to move and explore even in the winter months.

8. When renovations are planned, and especially when they are extensive, technical consultation should be made available to the centers, so that, for example, when a bathroom for children is installed, it has a sink that a child can reach. When possible, a play room should have water for water play readily available, and should have outside access to the play yard. Though all are not always possible, technical assistance would allow a PCC to make wise choices about the use of its renovation funds as well as its equipment funds.

C H A P T E R V

THE PARENT-CHILD CENTER STAFF

INTRODUCTION

The kind of experiences encountered by families enrolled in the Parent-Child Centers are in large part determined by the staff: the way in which the jobs have been defined, how the staff members have been trained and supervised, and how they function in their jobs. In this section we examine and describe how the Parent-Child Centers met the criteria established concerning PCC staff.

> A training program for both professionals and nonprofessionals. This program must have the capacity initially to train personnel for the specific PCC, but must be capable of training additional personnel at a later date. It must also include the recruitment and training of volunteers of many age groups and neighborhood residents to work alongside the professional staff.[1]

Data in this section are from several sources: the Staff and Volunteer Information Form completed by the staff of each center, reports of our field research associates, copies of training outlines sent by some of the center directors, as well as information from the first and second year proposals. These data are utilized to describe how the staff was selected, how roles were defined, the characteristics of the people who filled the positions in the PCC, how they were trained, and the type of staffing models which emerged.

DESCRIPTION OF STAFF

Number of Staff Employed and Ratio of Staff to Families

Of the 943[2] staff reported by the Parent-Child Centers, 553 full-time and 145 part-time are paid directly with PCC funds.

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 4.

[2] Four staff did not report whether they were paid or volunteer.

Other agencies have assigned 33 full-time and 20 part-time staff members to work with the centers. Of the 188 volunteers reported, only eight are full-time. It is very likely that there are many more volunteers working off and on, but they have not been reported by the centers.

The average Parent-Child Center is staffed with 21.5 paid employees, with a range from a low of three to a high of 39. Overall, the ratio of one paid staff member to 2.4 families enrolled, but the range here is also great. At one of the rural centers, where home visiting is the major program component, the ratio is one paid staff member for each family. At another rural center where day care at three separate centers is the major service, the ratio is one paid staff member to 5.6 families.

The Screening and Selection of Staff

The staffs eventually employed by the Parent-Child Centers were screened and selected in a number of different ways. Although the criteria specified that "Selection of the Program Director shall be made by the PCC-PAC after consultation with the Neighborhood Centers and the CAA,"[1] in practice this was rarely possible, since the Policy Advisory Committees had not yet been formed when the first directors were employed. Most were selected by the Neighborhood Center, the CAA director, and the delegate agency in agreement with the D. C. Coordinators. Other staff members were selected either by the CAA or the PCC director in consultation with community groups.

The criteria established for the selection of professional staff members--as well as the problems encountered and methods used in their selection--differ greatly from those established for the selection of indigenous aides in the PCC programs. Although there generally was an ample supply of professional manpower in the large urban areas, rural communities had virtually no choice of professional or administrative staff. A number of PCC's developed creative ways of locating professionals to compensate for the lack of such manpower in the target area. These included four areas that located either ex-VISTA or ex-Peace Corps volunteers to head the PCC program, one center that identified a number of married women with professional experience who could work part-time for the PCC, and another PCC that shared its professional staff with Head Start to make maximum use of limited available professionals. Merely because more professionals are available in urban areas did not necessarily mean that professionals were employed. Four urban PCC's employed no trained professional staff.

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 12.

The selection of the nonprofessional staff for the PCC's was subject to many community pressures. These jobs were often the best paying positions available in many poverty areas and it is not surprising to find that competition for them was intense. Qualifications and job specifications were left unstructured to allow for greater flexibility in selection. This combination of great competition for the jobs, lack of firm criteria for employment, as well as the fact that the channel established for staff selection (the PAC-PCC) was not operating when staff members were screened, resulted in the development of numerous community tensions and conflicts.

The amount of freedom the PCC director had in screening initial staff depended in large measure on the degree of organization and the political sophistication of the particular community. Where a community was well organized, the PCC director had little choice in the selection of staff as indicated by this report from a field research associate:

> Before being hired, all staff members were interviewed and screened by the CAA Board's Personnel Selection Committee and the PCC project director. The Committee and PCC director then presented their recommendations to the CAA director, who made the final selections. The CAA director had the final word with respect to who was hired and, conjecturally, who was fired.
>
> Other individuals and groups expressed an interest and made recommendations with respect to staff hiring. The most vociferous of these were the Motivation Against Poverty (MAP) groups composed of target area citizens. Several of these groups pressured the PCC project director to hire certain individuals whom they felt were particularly qualified, particularly deserving, or particularly in need of jobs.
>
> During her initial screening of applicants, the PCC director gave utmost consideration to the wishes of MAP groups because of their strong organization and because they were made up of the very people whom the PCC's serve. The PCC project director was eager to enlist the support and gain the confidence of the target community during the project's embryonic stage.

In most urban areas the PCC directors had limited choice in the selection of staff for the overwhelming decision was to hire target area residents and Blacks. Qualifications for the jobs were of less importance to the parents, the Policy Advisory Committee, and often the directors themselves. In some rural and southern areas freedom was considerable. In one such area, the director placed an ad in the newspaper and selected the PCC aides from more than 70 applicants who applied. He sought women with warm, supportive qualities, and the screening procedure paid off in that turnover among these aides has been low and every visitor to this center has commented on the unusually warm atmosphere. This freedom to screen and select applicants for qualities appropriate to PCC tasks was rarely afforded directors of urban centers, except in those PCC's connected to universities where distance from community pressures was greater.

In one of these, applicants for aide positions were interviewed by professionals, but selected by a panel of community people sitting in on the interviews. In some PCC's, humanitarian motives on the one hand, or political pressures on the other, led to the selection of aides who had the most need for a job rather than who showed the most potential for growth. In some other centers, those parents or community people who were active on the planning committee were employed as aides.

Whether or not professional staff were employed by the PCC's depended not only on their availability in the community but on the amount of pressure for self-determination and control of resources by the target area residents. In several centers, all northern, urban, and Black, the demand was not only to employ Black staff, but also that all staff should be low-income, thus precluding the selection of professional staff.

Characteristics of PCC Staff

As might be expected in a program focused on infants and toddlers, 86 percent of all PCC staff is made up of women, but at least one man was employed by all but four of the centers. For the most part the men employed by the centers are either professionals or maintenance staff. No men are employed as clerical workers; a few creative roles have been developed for target area men and these are described in the section on nonprofessionals. Most PCC staff members are young, one-fourth under 24 years of age, and 58 percent under 34.[1]

The ethnic composition of the PCC staff closely reflects both the geographic distribution of the centers and racial (ethnic) composition of the centers' clientele. Table 7 shows, for comparative purposes, the percent of each ethnic group employed as staff and enrolled as families.

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[1] For full information on all PCC staff, see Appendix A. For information on individual centers, see Progress Report No. 22, Feb. 1, 1970.

TABLE 7

Ethnic Composition of PCC Staff and Families
(in percentages)

	Staff	Families
	%	%
Puerto Rican	1	1
Mexican-American	7	8
Other Caucasian	36	27
Negro	42	47
American Indian	5	11
Polynesian	1	2
Oriental	1	0
Eskimo	1	1
Other	3	2
Not Reported	3	1

The largest percent of both staff and families are Black, but there is a slightly larger percent of Black families enrolled than are employed as staff. The same observation holds for all other minority groups. A larger percent of Caucasians (other than Puerto Rican and Mexican-Americans) are employed as staff than are enrolled as recipients of the program.

The ethnic characteristics of the staff vary with the location of the centers. Most of the American Indian staff is employed at the Parent-Child Center on the Indian reservation, most of the Black staff in urban areas, and most of the other Caucasian staff in rural areas.

Whether or not the staffs of the PCC's are integrated depends also upon the geographic location of the center. Of the ten Parent-Child Centers where more than 80 percent of the staff is Black, all but one are in northern urban areas. All three of the Parent-Child Centers where other Caucasians comprise more than 80 percent of the staff are located in Appalachian states.

In keeping with current national policy, pressure was put on the Parent-Child Centers in southern states to integrate the staff. In northern urban areas there was the acceptance of self-determination and Black power. Centers were permitted to employ only Black staff and serve only Black families.

If the present trend continues, the percent of Black staff employed by the Parent-Child Centers will increase. As shown in Item 6 of Table A-2 in the Appendix, the percent of Black staff who have terminated is smaller and the percent of other Caucasian staff who have terminated is larger than their respective overall representations on the staff. This same trend is found in the termination of families.

While every Parent-Child Center employs an administrator (one was temporarily without a director at the time this information was prepared) and all but one employed clerical staff, there is little else that is uniform about the staffing of the PCC's. As Table 8 shows, the only kind of professional staff employed by more than half of the PCC's is a nurse.[1] Social work aides, teacher aides and center or program aides are all employed by about two-thirds of the centers, however, their professional counterparts are employed by about a third of the centers.

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[1] A special condition of each grant was that a nurse be employed if children were to be served in groups. Thus the figure is lower than that which adherence to the grant condition would have produced.

TABLE 8

Professional and Nonprofessional PCC Staff Positions

Professional and Administrative	% of Centers Employing	Nonprofessional Clerical, Maintenance	% of Centers Employing
Administrative	97	Clerical	97
Social Worker	37	Social Work Aide	69
Teacher	31	Teacher Aide	66
Home Economist	20	Parent Educator	31
Nurse (R.N. or L.P.N.)	57	Nurses Aide	23
Child Development Specialist	29	Day Care Mother, Infant Educator	18
Psychologist	20	Center Aide, Program Aide	66
Nutritionist	0	Cook	34
		Transportation Aide	43
		Maintenance	43

Overall the ratio of professional to nonprofessional staff is one to four, but the range is from no trained professional staff at eight centers to a high of two professionals to one aide.

Directors

Probably the most crucial position in the Parent-Child Center is that of the Project Director. Much hinges on the person selected to fill this complex and demanding role. Four separate areas of competence are expected of all PCC directors; they must have skills necessary to operate effectively:

--In the larger community: The director must relate to the local political structure, including the CAA, professional agencies, and community institutions and must be able to develop an ongoing local matching share for the PCC budget.

--In the target area community: The director must be able to relate not only to the conditions and needs of the poor, but to the poor themselves. Relations must be maintained with the poor who are accepted in the PCC and with those who cannot be accepted into the program.

--Within the federal structure which regulates and funds the Parent-Child Center.

--In the internal operations of the Parent-Child Center: The director has the responsibility of taking a major role in recruiting, selecting, training, and supervising staff; planning, developing, and implementing an innovative program; establishing and maintaining a record-keeping system, and maintaining the morale of the staff.

The 35 Parent-Child Centers have a total of 37 directors, since two centers have administratively autonomous sites, each with its own director and supervisory structure. Eleven men and 26 women direct these centers. The directors include one Eskimo, one Puerto Rican, a Mexican-American, 20 other Caucasians and 14 Blacks; all 14 of the Black directors are in urban areas. All but five of the 35 directors who reported their educational background have college degrees. The largest number, 11, have a bachelor's or a master's degree in education. Seven directors have graduate degrees in social work, eight have degrees in the social sciences including one Ph.D. in psychology, and four have "other" degrees including a degree in business administration, and one in home economics. While most of the directors have previous professional experience as teachers, social workers, or as volunteers in community development, only about a fourth have previous administrative experience.

Considering the demands of the job, the directors are not particularly well paid. One director reports a salary of less than $7,000 a year, two report receiving about $8,000, and six less than

$10,000. With the exception of the one PCC that is a research program, no director reports a salary of more than $12,000. By the end of 1969 there had been a turnover of more than one-third of the directors. Some left for jobs at higher salaries, some left because the demands of the job were too great, and some were pressured into leaving either by the local community or the national staff.

Professional staff employed in significant numbers by the PCC includes social workers, nurses, teachers, and child development specialists. The roles filled by these professionals are described in the appropriate sections: programs for children, medical, and social services.

The Nonprofessional Staff

Nonprofessional staff members play an important part in the delivery of service within the Parent-Child Centers, for 57 percent of all staff are in this category, providing direct service to families and children. A total of 452 staff members, or about 60 percent of all PCC employees are target area residents, and in two centers 94 percent of the staff are local residents. Included in this number are 146 parents and other relatives of PCC children who account for about one in five of the staff employed in the PCC's. This emphasis upon employing target area residents is reflected in the educational level reported by the staffs. Seventy-eight percent of all staff members have no college degrees and 28 percent report ten or fewer years of education. In five of the PCC's, more than a third of the staff reports less than eight years of formal education.

Most nonprofessional PCC staff members have had no previous experience in the kind of work they are presently doing. However, more than one-third of professionals and nonprofessionals combined were previously employed in Head Start or other poverty programs.

Because of the limited education or experience of the nonprofessionals, the training and supervision provided for them in the PCC's are crucial to their development. Some centers defined the role of the nonprofessional as a general assistant in the operations of the program and called these workers "Program Aides," "Community Workers," or "Family Workers." Others created specialized roles such as "Teacher Aide," "Social Service Aide," "Health Aide," or "Infant Educator." How broadly or how narrowly the role was defined later determined both the training required and the job eventually undertaken. As discussed in the next section, the majority of PCC's had preservice training programs of less than four weeks. Given this limited time, it would at first glance appear more realistic to define specialist roles for nonprofessionals. To teach one professional skill in a four-week training program is already very ambitious; to try to combine some of the skills of the teacher, the social worker, and the nurse in this period of time is patently impossible. However, those centers which defined specialized roles for the aides encountered other problems when they implemented the programs. As one field staff reported:

> ...at this center, families are barraged by four different workers from the PCC. One mother complained that it seemed that no sooner had she closed the door on the health aide, but the parent education aide arrived. Though staff meetings are held weekly, there is not always enough time to compare notes on all families, and communication difficulties have developed between the aides and the families. Furthermore, in such a widespread area, most of the staff spend most of their time travelling. Travel and in-service training accounts for nearly two-thirds of all staff time in this center. I would certainly recommend that the aides be trained for more general skills to limit the amount of travel and so that only one staff person is responsible for visiting each family.

The role and task definition of the nonprofessional workers has been a difficult issue for Parent-Child Centers to resolve. On the one hand, a broad and comprehensive program such as that envisioned by most PCC's, requires broad and comprehensive skills. These are not easily found in professional workers let alone quickly trained in nonprofessionals. Most centers, when faced with this dilemma, gave titles of specialists to their nonprofessional staff, but did not do specialized training during the preservice sessions.

Clerical Staff

Every center except one employed at least one clerical worker. Many of the Parent-Child Centers viewed clerical positions as good training slots for untrained and inexperienced community people. Others hired trained and experienced secretaries and bookkeepers. Since filing and record-keeping systems had to be planned and established, it goes without saying that those centers which hired bookkeepers who could add, and secretaries who could spell and type as well as organize files had an advantage over those who attempted to teach these basic skills on the job.

STAFF TRAINING

Preservice Training Programs

Whether or not a staff member received training before starting work depended upon the particular center by which he was employed and whether he was employed at the onset of the program or at a later date. While 31 percent of all staff reports receiving no preservice training, the percent ranged from two centers where all staff reported some preservice training to one center where no staff member reported such training. Staff members employed after the initial preservice training program were apt to start work with no preservice training at all. Although guidelines specified that

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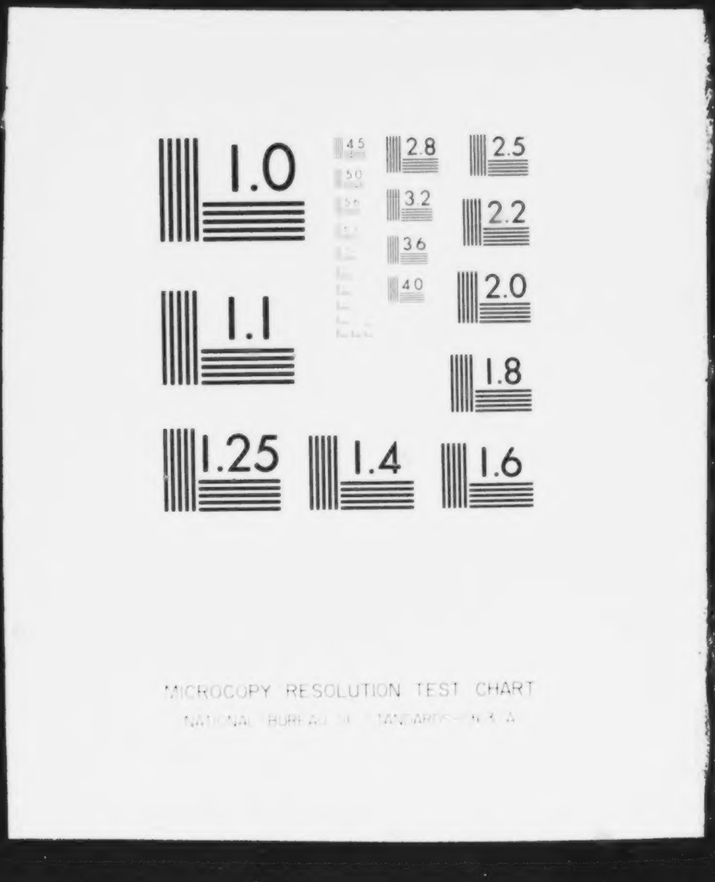
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NATIONAL BUREAU OF STANDARDS-1963-A

preservice training could extend over a three-month period, only six centers had training lasting more than 12 weeks as shown in Table 9.

TABLE 9

Preservice Training

Length of Training	Number of Centers*
None or less than one week	7
1 - 4 weeks	18
5 - 12 weeks	3
13 - 22 weeks	3
More than 23 weeks	3
Not known	1
	35

In two of the three centers where training lasted for more than 23 weeks, it resulted from the fact that the physical facilities were in the process of renovation and were not ready for occupancy. These centers continued training until their centers were ready for use by children and parents. Most centers provided between one and four weeks of preservice training.

Even those PCC's which provided no formal preservice training to staff at least offered an orientation to the policies and goals of the PCC and an orientation to other poverty programs as indicated in Appendix A. As Item 14 of Table A-2 shows, 97 percent of all Parent-Child Centers provided some orientation to these issues, as well as to Child Care and Development. This table also shows that far more centers provided, and more staff members received, orientation to policies of the PCC than specific techniques for working with either infants or families. However, as Table 10 indicates, seven centers also provided training for some staff members in the sequential development of infants and the skills and activities appropriate for specific age levels.

TABLE 10

PCC Training for Work with Children

Content of Training	Number of Centers*
General Program Content Training: community resources, child growth and development, health, nutrition	33
Structured Intervention Techniques: sequential development, appropriate age level toys, skills, behavior	7
Process: sensitivity training, self-awareness, encounter groups, personal staff development	9

* More than one category is possible in any center.

In addition to content training, nine Parent-Child Centers provided their staffs with various kinds of experiences aimed at developing intrastaff communication and encouraging self-awareness. These techniques included encounter groups, sensitivity training, and role playing; at one center sensitivity training alone was provided with no skill or contact training. The director of this center reported that she felt the "feeling tone" of the staff to be more important than the content of training. The following quotation from a report of one of KAI's field staff is an example of this type of training.

> The staff held a three day "communications lab" as an in-service training device with the regional director

> of the Presbyterian Synod of Appalachia from Knoxville, Tennessee. The director feels that this experience turned the staff into a "group." Overall her reaction to the experience is highly enthusiastic. She feels the staff members are now "sensitive to the needs of each other," that "former conflicts between persons have been resolved," and that they are "more tolerant of differences among them." She feels that whereas "their reaction was formerly basically emotional, it is now more intellectual." In addition she feels the three-day session "helped staff improve their own self-image." The director sees a continuing need for developing still better working relationships with each other.

More than two-thirds of the Parent-Child Centers utilized professionals from a wide variety of different colleges and universities in the preservice training of the staff. Consultants from some of the best known colleges and universities provided one or more lectures or teaching demonstrations. Included among the universities were Johns Hopkins, Howard, Temple, the Universities of Pennsylvania, Florida State, Oregon, Chicago, Southern California, and Louisville as well as many four-year colleges and junior colleges. Active in the implementation as well as the planning and development of training were the Project Advisers and the University Affiliates of 17 of the Parent-Child Centers. As discussed in the section describing the work of the University Affiliates, preservice as well as ongoing training and consultation were the major roles of 11 of the University Affiliates. Four PCC's arranged for most staff to be trained outside of the PCC through colleges or government-funded training programs. Table 11 shows the sources of staff training.

Preservice training programs in the PCC's ran the whole gamut from "superficial and disorganized" through "well-structured and intense" according to the reports of the field research associates. These programs have also varied from discussions and vague generalizations about the problems of the poor to highly focused, specialized, and differentiated training for various classifications of aides.

TABLE 11

Source of PCC Staff Training

Staff Training Conducted by	Number of Centers*
Professional Staff Only	4
Professional Staff and Consultants	25
Project Advisers and University Affilitates	17
Trained outside of PCC (Title V, Project Mainstream, local colleges and universities)	4

* More than one category is possible in any center.

Those four Parent-Child Centers which arranged for training to be done outside of the PCC itself--under Title V funds at a university, by Ira Gordon at Florida State University, or in a 45-week child care training program at a local college--thus freed the professional staff for program organization, curriculum development, and making of physical arrangements rather than the day-to-day supervision of staff training. Later a limitation of this type of training appeared, however. Since professional staff was not involved in the training process, and sometimes was not even cognizant of techniques taught, ongoing supervision proved difficult.

About a third of all PCC's either had no training at all, or had poorly planned and disorganized training. An example of this type of training being conducted four months after the staff had first been employed was described by a field researcher:

> Training has been haphazard and infrequent. It has consisted primarily of reading textbooks and writing summaries of occasional chapters. The director has

> protested that her work allows her too little time to participate in training, and has mentioned numerous ideas for supplementary staff training through outside agencies. No such supplementation has yet taken place.

Between a third and a half of the PCC's had training which might better be illustrated by the following statement:

> The director was aware that staff needs would not end with recruitment but would require extensive training. She began the program with a two-week orientation period which described the relationship of the PCC to the CAA, the goals of the PCC program in general, and the specific aims of the local program. Great stress was placed on the need to work across professional boundary lines if a total family help program was to be developed. This orientation might be described as imparting the philosophy of the PCC and giving the professional staff and aides an opportunity to meet one another rather than providing training in specific skills to do the job.

Somewhat fewer than a third of the PCC's had preservice training which was described as "well-organized and directed." One such example is described by our field staff:

> The staff received about a month of preservice training, planned and coordinated by both the Project Adviser and the University Affiliate. Some training sessions included all staff members, but separate sessions were also provided for the educational aides, the health and the social service aides, as well as the parent coordinators. These sessions used a variety of techniques including lectures, films, discussions, and participatory workshops. Role playing was utilized as a major technique for teaching work with children as well as with parents.

Two of the Parent-Child Centers that made the decision to employ only local residents rather than professionals, also planned to make training and supervision of the staff the major focus of the PCC. At one of these centers there has been no real line of demarcation between preservice and in-service training--rather training has been a continuous process. This is described by a field associate in the following way:

> In developing the program, probably one of the most important decisions made was to provide the staff with as much training and supervision as possible. Since then, training sessions of several days to a month's duration have been held. In addition staff meetings are held weekly and, on the average, a half day a week of in-service training and supervision is offered.
>
> During January and February of 1969 there was a one-month training period which included all of the supervisory and aide staff. The focus of the training was on interviewing techniques, child development theory, health (prenatal, postnatal, and early childhood), agency resources in the community, and general psychology.
>
> Immediately following this month of training, consultants were brought in for each of the departments. The child development specialists had a half day of training each week until June. The focus of these sessions was motor and perceptual skills.
>
> The language specialist was then brought in for about 14 weeks on a half-day-a-week basis and she taught skills and ideas related to the development of language in small children. Occasionally the staff members made trips to other community agencies to talk with their staffs and to learn about their programs.
>
> The social service staff spent on the average of two days a month in training along with the NSP social service staff. This began in February of 1969 and lasted until September. Since September they have been spending a half day each week in training sessions led by graduate social work students from the university.

A number of the professional staff at the PCC's reported that training after services to families began was more meaningful than that provided prior to working with families, since preservice training was all abstract and related only to theoretical situations rather than to real life ones. As one social worker reported:

> At the end of training the indigenous staff felt ready to take on dozens of cases. However after being assigned five or six families, they said they could not handle any

> more. They went through a period of severe depression once they found out how many problems the families had and how difficult and time-consuming it was to try to find resources to cope with the problems. One of the aides recently off welfare herself said, "How do welfare workers manage with 75 cases?"

This supervisor goes on to describe the importance of moving directly from the preservice training into work with families and of providing intensive supervision and in-service training to avoid anxiety on the part of the nonprofessional staff.

In-Service Training and Supervision

In-service training and supervision in the PCC's has been as varied as the training provided before services to families began. Almost all of the Parent-Child Centers took part in regional training sessions called "mini-conferences." These were two- to three-day conferences, loosely organized with a variety of types of curricula depending upon the organizer and the area served. Some focused on infant development, others on general problems of the PCC's, and at least one on community organization. These conferences did provide a needed opportunity for the staffs of several PCC's to discuss their experiences, progress, and problems.

About half of the PCC's have not instituted any regular in-service training program but have supervisory conferences and occasional speakers. Fourteen of the centers devote one full day a week to in-service training and staff meetings, plus additional time in supervisory sessions. While some centers, particularly those that provide full-time, center-based day care for children, schedule little regular in-service training, others devote more than 30 percent of all staff time to ongoing training. One PCC suspended its services for much of the summer to allow the staff to attend training sessions at the local college. Much of the in-service training has been rich and varied and generally more specialized and directed than the preservice training. It seems fair to state that many centers did not know what they needed to know until after the program began. Once they found what they needed to know and who needed to know it, training was both better planned and better received. In addition to training provided within the PCC, a number of centers have arranged for their nonprofessional staff to take courses at local junior colleges for credit. Others have enrolled staff members in Red Cross First Aid classes, a 20-week Nurse's Aide training class and a 45-week university-sponsored child care class. Many staff members in urban areas attend classes in Black history and cultural heritage.

Very closely related to the in-service training programs are the supervisory conferences and training provided by the professional staff. To understand this, it is necessary to describe the various ways in which PCC's are staffed and supervised, which are detailed in a later section of this chapter.

Training of Volunteers and Professionals

In addition to training its own professional and nonprofessional staff, the PCC's are providing training for three other groups--adult volunteers, Neighborhood Youth Corps (NYC) and other teenage youth, and students in professional training.

A total of 189 regular volunteers have been reported by the centers, but it is believed that there are many more volunteers active than have completed the data forms. These volunteers sometimes come from religious or service groups such as the Council of Jewish Women or the Junior League, or sometimes individually. A number of centers have been assigned VISTA volunteers. Nearly all work part-time, but eight centers have each recruited one full-time volunteer. Orientation is provided for all of these volunteers by the staff of the PCC's.

Many centers have recruited teen-agers as tutors, recreation aides, or program assistants. Particularly during the summer, NYC workers were assigned and trained in the PCC's.

A third group being trained are students from professional schools on field placements in the Parent-Child Centers. At least five centers and perhaps more have social work students for a full year of field placement. Three have Ph.D. candidates in psychology who help with data gathering, testing, or clinical work. Many have education students doing field observations. Pediatric residents have been assigned to one PCC and medical interns to another. At one center pediatric residents visited the homes of low-income families with PCC aides--an innovation in the training program of that medical school.

In addition to providing these three groups with experience in working with low-income families, every Parent-Child Center provides speakers and tours of its facilities and programs to visiting dignitaries, local contributors, interested professionals, and student groups. These public relations programs are in the broadest sense part of the community education program of each PCC.

Staff Turnover and Training

Twenty-seven percent of the overall staff originally employed and trained by the Parent-Child Centers were terminated during the year. A third of the staff worked less than three months and two-thirds less than six months. About 22 percent of those terminated left because the PCC job was only temporary, usually summer recreation work. Only about 19 percent left to take another job, and most of these were the administrative and professional employees.

Turnover among some kinds of employees was higher than for others: a larger percent of professional and nonprofessional staff members were terminated than their percent in the population of PCC staff. Turnover was higher for young staff under the age of 24, for staff with either an elementary school education or a college education, and for Caucasian staff members than the percentages of these categories in the total staff population. Those less likely to terminate than their percent in the staff population were the Black staff members, those with a high school education, those with prior experience in poverty programs, and those with children enrolled in the PCC program.

Several PCC's which had only recently employed their staffs reported no terminations; one PCC in operation more than a year reported only one staff member terminated. However, one PCC had a 100 percent staff turnover, and two PCC's replaced nearly 70 percent of their staffs. One of these had a complete turnover of administrative and professional staff, and at the end of the observation period was seeking its third director. Another had terminated two directors and all of its other staff. The amount of turnover of staff members is important in terms of program continuity, relations with families, and the cost of retraining new staff. One center, after spending three months training its community workers, terminated nearly two-thirds of them within less than two months after service to families began. The need to recruit and select new staff plus the fact that such a lengthy preservice training program cannot be provided while the program is operating makes this staff turnover very costly. This was aptly described by one of the field associates who reported, "When this center lost its Ph.D. in psychology, it did not represent any real loss to the PCC. The director merely called the university and asked that another one be assigned. On the other hand, when two aides left, it represented a loss of nearly one-sixth of the first year's investment in training." Ordinarily the loss of the more highly trained, educated professional is considered as a greater loss, but since professionals are trained outside of the PCC and nonprofessionals are trained within the PCC and out of the PCC budget, the loss of a nonprofessional is a far greater one. For those centers which are investing as much as 30 percent of all staff time in ongoing training, the replacement of a nonprofessional staff is very costly.

As programs were implemented and staff members left, few centers have provided any but the most cursory of preservice training for new aides due to the pressures of ongoing service. The high cost of retraining staff members within the PCC together with the difficulties of providing preservice training and services at the same time, particularly in centers with very limited professional staffs, have led several of KAI's field staff to suggest that training for PCC aides might best be arranged or contracted for outside of the center. Where colleges or universities are available, course work and training in these institutions could precede on-the-job training in the center. Such an arrangement would also provide some credit or type of credential for the nonprofessional.

Although the criteria specify that the PCC's serve as a site for ongoing training of PCC personnel, this has not really proved possible. The needs of the children and the families, once services are implemented, have taken priority on staff time, and it is unlikely that any training other than field experience can be provided by the operating Parent-Child Centers.

STAFF ORGANIZATION, ACTIVITIES, AND RELATIONS

Organization of Staff for Delivery of Service

There are five different models by which Parent-Child Centers are staffed to deliver services. In three of the models the primary contact with the client is made by the nonprofessional staff; in one model most of the contacts are by the professional staff; and in the fifth, contacts are made by both the professional and nonprofessional staff. These models define both the supervisory relationship and the delivery of service to the children and families.

Of the 34 PCC's with families enrolled, there are 21 programs in which the primary contact is between the nonprofessional and the client. These are structured in three ways:

Model 1 - (4 Urban PCC's)

Professional Staff
↓
Nonprofessional Staff
↓
Parents
↓
Children

In this model the nonprofessional staff is supervised by the professional staff; nearly all contacts are between the nonprofessionals and parents. Though children may be present during the contacts, the primary focus of the contact is in providing support services for the parents. This staffing-client model makes the implicit assumption that once the needs of the parents are met, "better parenting" will result. All four of the urban programs staffed in this way deliver most of their services in the homes of the PCC clients.

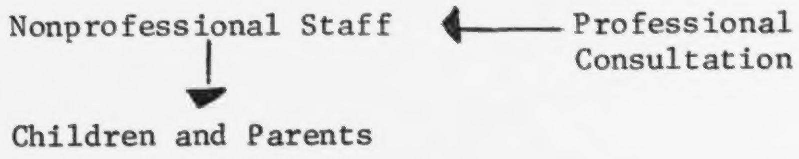
Model 2 - (4 Urban, 5 Rural PCC's)

Professional Staff
↓
Nonprofessional Staff
↓
Children and Parents

In this model the professional staff supervises the nonprofessional staff members who work directly with both children and parents. The four urban centers staffed for service by this model also have most of their services in the homes. The professionals rarely visit in the homes.

The five rural PCC's staffed along this model all have a low ratio of professionals to nonprofessionals and operate programs both in the homes and in from two to five centers. This model makes maximum use of limited professional time.

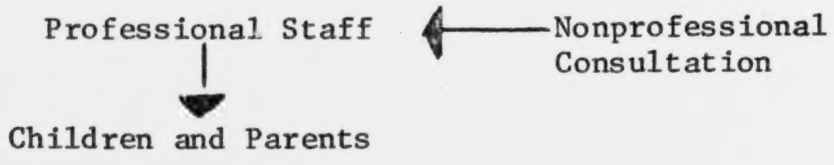
Model 3 - (4 Urban, 4 Rural PCC's)


Nonprofessional Staff
Professional Consultation
Children and Parents

In this model all staff is nonprofessional. (In four centers the director has a B.A., but acts as an administrator rather than a supervisor.) For the four rural PCC's, this staffing model is the result of the lack of availability of professionals for employment. In one of these PCC's, even the professional consultation is extremely limited due to the extreme isolation of the two sites established. The reason for the staffing pattern in the four urban centers is related to the Black activist goals of self-determination, and control of resources--in this case, jobs for local people. Three of the four urban PCC's have made extensive use of volunteer professional consultation and training.

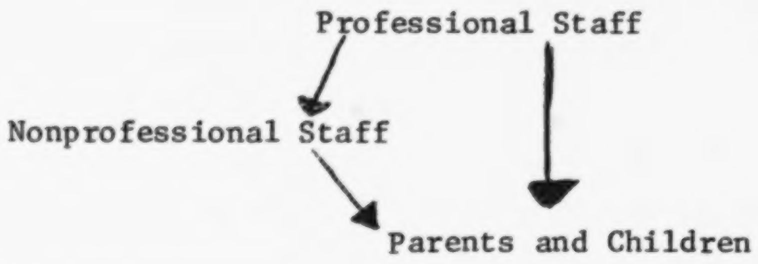
The 13 programs in which contacts with clients are made by professional staff include two models.

Model 4 - (1 Urban PCC)


Professional Staff
Nonprofessional Consultation
Children and Parents

While only one urban PCC is staffed to deliver services in this way, it is a model quite prevalent in traditional preschool and service programs. All staff are professionals; the only nonprofessionals are the clerical workers. What this program refers to as "indigenous workers" are Spanish-speaking staff who are either college students or Ph.D. candidates rather than low-income target area residents. This program is highly research-oriented and the delivery of service is secondary to the basic research planned.

Model 5 - (10 Urban, 2 Rural PCC's)



In this model the professional staff supervises the nonprofessional staff, but they function as a team in their contacts with both parents and children. All of the programs staffed in this way have a center-based operation with a nursery or day-care program for children. Professional teachers and child development specialists as well as community aides or teacher aides work together to provide educational programs for the parents and the children. In five of these programs, professional staff makes home visits along with the aides. This model provides maximum opportunity for in-service training of nonprofessional staff. This model requires a high ratio of professional to nonprofessional staff.

Each of the models has advantages and limitations. Of the 21 programs staffed so that almost all contacts are between the nonprofessional and the client, all have the advantage of making maximum use of limited professional personnel. The nonprofessionals have the ease of communication and of access to the target families so frequently described in recent literature. On the other hand, this model provides little or no opportunity either for direct work with children or for groups of children to be together since most of the contacts are in the home. All three of these models place the professional staff member in the role of "instructor" who tells the nonprofessionals what to do rather than as a role model who "demonstrates" skills. Nonprofessionals do not get much opportunity to observe if the information the professionals impart really works. Where the program is both home and center based, it is almost always the nonprofessionals who make the home visits and the professionals who stay at the center or in their offices. This creates both a status hierarchy and a supervisory gap. At a number of centers, the "better" jobs for the aides are the center-based ones, since these are more like the jobs which the professionals have. Further, just as the nonprofessionals have little opportunity to observe the professionals at work, the professionals have little opportunity to observe how the nonprofessionals are doing their job. Professional staff must depend on what the nonprofessionals report they did. This kind of structure has not provided optimum communication or learning conditions. In areas of severe shortage of professional personnel, however, these models may be necessary.

Model 4, which is entirely professional with nonprofessional consultation from the Policy Advisory Committee, is appropriate for the purpose developed--conducting basic research.

Model 5, in which both professionals and nonprofessionals work directly with families and have the opportunity to act as a team and learn from one another, appears to have many advantages both from the viewpoint of training and supervision and of delivery of service. Programs staffed in this way provide an excellent situation for on-the-job training. Direct contact between professional staff and families has the additional advantage of sensitizing professionals to the developing needs of the clients. This model is being used in six northern urban ghettos; four of these have only Black professionals employed, but two have an integrated professional staff. An example of this latter type is described by one of the field staff:

> The staffing method employed in this center seems superior to what I have observed in other centers. The use of trained personnel in direct service activities with nonprofessionals under their supervision works well here. Part of the reason for its success is that the professionals are not parading their training and are hard at work. Perhaps few centers could get together a humble nurse, a teacher who fits in like an old shoe, and a child development coordinator whose protestant ethical thrust is directed at herself and the director, first and foremost. Whatever the cause nonprofessional poverty-level staff members are working hard side by side with "suburban types" and discussing center problems on a woman-to-woman basis.
>
> The staffing method seems inherently superior to one in which professionals are desk bound (above work with children?) or in which the professionals' contacts with nonprofessionals are limited to a few hours a week.

All programs staffed in this way have a major portion of their service delivered in the center, so that the facility serves as a training laboratory. All 12 of these programs have a higher than average ratio of professional to nonprofessional staff, and most have fewer than average families enrolled. Thus the model is probably only appropriate to urban areas or to those rural areas that can both attract sufficient professional staff and bring families to a central facility. Nonprofessionals had been used in this manner long before the poverty programs. Hospitals, childrens' homes, day-care facilities, and mental hospitals have used and supervised nonprofessionals in this way for many years. This was also the staffing model suggested when nonprofessionals were first suggested to extend services in low-income areas. Given the necessary conditions, this model has much to recommend it.

Staff Activities

Information about how the staff spends its time comes from two sources: the Staff Activity Report[1] completed by individual staff members and volunteers at the centers and from the observations and reports of our field staff. Both sources have their limitations. The staff members are apt to overreport their activities as in the case of the cook from one center who reported working 293 hours in one week, or an aide who instead of filling in the "number of hours worked this week" wrote, "round the clock." The observations of the field staff are affected by the limitations of the method. A day when an "evaluator" is scheduled to arrive is rarely an average day. Most centers make the effort to have the program operating "at full steam." The presence of the observer distracts some staff and occupies others. In many areas the two sources of information tend to confirm one another. Where they do not, a point is made of the discrepancies.

Direct services to families was reported for about half of all the time of the combined PCC staffs. The amount of time spent in direct service to family members ranged from a low of 29 percent to a high of 75 percent. The field observers reported a range down to 20 percent. The centers reporting the most direct service were those that operated a day-care or infant-toddler program at the center or home day-care groups. The least amount of direct service was in programs where the home-visiting component was large. The most staff time was spent in direct service in centers where the director had a degree in education, and the least where the director had a social work degree.

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[1] A copy of the Staff Activity Report is included in Appendix A. Details on how this report was distributed and analyzed are included in Progress Report No. 19, November 1969. Only the findings of those reports returned will be discussed here.

Administrative matters, including record keeping, in-service training, supervision, staff transportation, and maintenance consumed more than 39 percent of the time of all staff. The amount of time a particular staff person spent in administrative matters was lowest (31 percent) when the director was an educator, and highest (63 percent) when the director was a social worker. There seemed to be no relationship between how long a program had been operating and how much time was spent in administration. It had been expected that once programs were fully established, the amount of time spent in administration would decrease and the amount of time spent in direct service would increase, but this does not seem to have happened. As time has passed, more time seems to have been allocated to in-service training.

About 11 percent of all staff time was reported spent in meetings both with other staff and with community members, although nearly all of this time was spent within the PCC. Staff members reported as little as five percent and as much as 26 percent of time spent in staff meetings. The field staff reported that at several centers up to half of the time seemed to be spent in casual conversation with other staff, if not in formal staff meetings.

According to the reports of the staff, children under the age of three account for the largest number of contacts with PCC staff, and of course this is heavily weighted by those centers having a five-day-a-week day care or play group program. Children older than three years account for the next largest number of contacts, followed closely by mothers. A little more than five percent of all contacts with PCC staff were with whole families.

Contacts with fathers were nonexistent at many centers, and occurred with any frequency in other centers only when a potluck dinner, social, or picnic was held.

When the activities and services provided to families were ranked in order by the number of hours invested in each, day care naturally led all the rest, even though this activity was provided by only ten centers. Listed in the order in which staff time was allocated by all the PCC's, the activities and services were:

1. Day care
2. Meeting the physical needs of families: food, clothing, housing assistance, providing lunches, etc.
3. Play groups for infants and toddlers
4. Recreation for whole families
5. Infant cognitive stimulation
6. Transporting families to center and services
7. Counseling
8. Health care
9. Baby sitting
10. Home visits
11. Family life education
12. Consumer education
13. Referring clients for other services, finding referrals
14. Academic classes for parents, tutoring school-age children

While the services and activities of the staff vary widely from one center to another, overall the staff members of the Parent-Child Centers report the largest share of their time spent in providing day care, play groups, and infant stimulation to children under the age of three, and to meeting the physical needs of the whole family by providing lunches, food, clothing, and assistance with housing. Providing recreation for families is one of the major activities of the staffs. The amount of staff time allocated to providing transportation for families is larger in rural than in urban areas, but consumes an important share of staff time for all centers.

There is little disagreement between the reports of the staff members themselves and the reports of our field observers about what the staff does. Where the two sets of information do not agree is in how much time the staff devotes to the activities and services it provides. Though there are several notable exceptions, many observers reported that the administration and supervision of the PCC programs was loose and disorganized, and that much of the time the staff members were underemployed or kept at irrelevant tasks. Comments such as these are frequent throughout the reports.

> The staff at this center spend their time in endless pursuit of trivia....When I asked one of the family workers what he had done during the course of the year, he could only account for about three days of work. It was not that he had not come to work, but merely that he could not cite any concrete examples of tasks.
>
> The staff drifts in between nine-thirty and ten A.M. Each makes her own breakfast, and they engage in small talk about events in the community or about their own children. At about 11 the director arrives, and there is a brief flurry of papers, but that ends shortly as staff members begin to discuss where they will have lunch.
>
> With 27 staff persons employed and 15 families enrolled, this staff is underemployed; especially since attendance in the nursery runs between 20 and 30 percent.
>
> The community workers in this program seemed overwhelmed with their own personal burdens, which heaven knows are enormous. Professional staff members must spend a large portion of their time providing support and trying to solve the serious problems of the indigenous staff.
>
> The program was virtually suspended for the past six weeks because all but two of the community workers were out on sick leave.
>
> The satellite center, rather than a drop-in center for families, seems to be a drop-in center for the aides. Here they can gather away from the director and their supervisors, and out of the cold.

> This staff seems like a sincere, dedicated group of women, desperately in search of some direction, leadership, and structure.

An analysis of those programs that have not shared these difficulties provided no findings that previous studies of the use of nonprofessionals had not yielded. Further, the conditions that produced more output by the PCC staff are the conditions that apply to any staff. Turnover was reduced and performance enhanced when:

--The goals of the program were clear and articulated rather than broad and ill-defined.

--The staff organization was clear, roles defined, and people trained to fill the assigned roles.

--When there was a professional staff, rather than none; when the professional staff had prior experience in administering programs and providing supervision.

--When the professional staff demonstrated skills directly rather than described them, and when supervision was direct and in the field if necessary.

--When the nonprofessionals were selected for aptitude rather than for need of a job.

--When the task of the nonprofessional was defined and training was specific to the tasks assigned.

--When social services and supports were provided for the nonprofessionals who were a part of the client population.

These conditions are more apt to exist in programs which are center rather than home based, for definition of task as well as supervision is easier within the confines of a center than in the field. However, at least two rural programs with major home-visiting components managed to structure, train, and supervise aides to meet reasonable standards of attendance and performance. Of the relationship between the nonprofessional and the professional staff of one of these centers, the field observer writes:

> On many occasions the untrained staff has demonstrated intuitive skill in dealing with program participants with the result that professional staffers have been taught as well as called upon to teach. In the words of the director: "Together we learned and still are learning to use each other and take from each other what each has to offer."

The innovative aspect of the use of nonprofessionals is their use in home visiting, either to provide social services or as parent educators, and it is in this home-visiting aspect that the attendance of the nonprofessional staff is least and their activity minimal. The demands of a center-based program with infants and toddlers in attendance are such that staff must work. While getting nonprofessionals to visit families regularly in an outreach program may be difficult for most centers, it is not impossible. Both the rural centers that are using aides for home visiting most successfully have defined their goals rather specifically, have defined the roles of the aides quite concretely, and have trained the aides to fill these roles. Neither of these programs has employed members of target families as outreach workers. While firm conclusions cannot be drawn at this time, it seems that it is necessary to do more careful selection of those nonprofessionals who will work in the relatively unsupervised field situation than those in the center program. And it may be that parents of program-eligible families have too many personal problems and to little work ethic to function outside of a structured setting.

Staff Relations

More than half the content of the reports of the field research associates deals with descriptions of the staff members and of their interrelationships and conflicts. The reports provide a chronicle of the infighting between the professional and nonprofessional staff, between the staff and the Policy Advisory Committee, between the staff and the CAA or the target community, or between the staff and PAC on the one hand and the funding agency on the other.

There seems to be no purpose served in either recounting the types of conflict or in describing the causes, since conflicts within the PCC's are much like those prevalent in the larger society. Long standing inequities between the races have produced bitterness, hostility, and defensiveness. The staff of the PCC is not immune from these conflicts. Within the PCC, as within any similar program, there are clashes between the expectations of the larger society and the needs of the poor, between middle-class demands and lower-class life styles, between the culture of the dominant American system and that of the Eskimo, the Thlinget Indian, the Mexican-American, or the White mountaineer. Rather than recount the varieties of conflict in the PCC's, it seems more important that stress be placed on the fact that conflict is a part of the process of social change. Conflict is an indication of growth.

What is important here is not that conflict has occurred, but that the opportunity for growth stemming from the conflict has been provided to many of the staff. For the first time, Black staff members who never before had had the opportunity to confront a White person, found this opportunity in the PCC. Mothers, who never had had anywhere to go in the morning, now had a supervisor who demanded that they come to work on time. Poor target-area people not hired for PCC jobs got angry, but never before had they expected to get a job. The staff, the poor, and the agency representatives on the Policy Advisory Committee grew angry at the red tape, the bureaucratic delays, and the refusal of the national funding agency to approve their plans, but a year before they had had no plans.

It is therefore not the conflict itself, but the management of it that makes the difference between a growth-promoting experience and a stifling one. One center director recognized the uses of conflict and found effective ways of harnassing it for the development of the staff, as described by one of our field observers:

> The director has also encouraged an open system of confrontation in the face of emerging conflict or difference of opinion between staff members. As a result, differences have been discussed and dealt with properly before permanent rifts could develop. And the professional

> staff has learned as much from the nonprofessionals as it had taught them.

This is not to imply that all conflict facilitates growth or the implementation of program, for conflict among the PCC staff members has at times reached the point at which work all but ceases. This internal conflict has often led to a great deal of staff turnover. Conflict is always greater in unstructured situations, where roles are ill defined and people are unsure about how to fill the roles to which they are assigned. It is not surprising to find that internal conflict is minimized in those situations where the goals are clear, where staff have been assigned to roles they understand, and where they have been trained to perform the tasks assigned.

Field research associates were asked to complete two scales describing the internal and external relationships of the Parent-Child Centers including intrastaff relations. These scales along with the mean ratings and the distributions of ratings for the 26 centers on which the scales were completed are shown in Tables 12 and 13. No extensive analysis or interpretation has been done of the scales since they are subject to severe limitations. Not only are there all the problems of inter-observer reliability, but also the difficulty involved in generalizing about a whole staff on the basis of a few observations of some of the staff members. Further, information for some of the ratings was dependent upon the reports of the PCC director or other staff persons and could not be observed directly by the field associates. Because of these severe limitations, only three interesting findings will be discussed.

1. Although the field associates had described conflicts among the staff at length, when asked to rate the relations of the staff on a five-point scale with one as most positive and five as least positive, they rated most staff relationships on the positive end of the scale. Though intrastaff relations at some

individual centers were rated in the two negative positions, overall, all relationships were rated more positively than negatively. Relations between the staff and University Affiliates, consultants, field research associates, and visitors were generally more positive than among the staff members themselves. Relations between professionals and nonprofessionals were only slightly less positive than among nonprofessionals on a peer level.

2. There was an inverse relationship between ratings of the external and internal relationships. That is, a center beset with external conflict and hostility with the CAA, with public agencies, with the larger community, or with the funding agency, was rated more positively in its internal relations. The presence of external discord seemed to increase internal harmony among the staff. In one southern PCC which had integrated both the staff and the families served, the external community was extremely hostile to the PCC, to the extent that some merchants even refused to sell to the PCC, but relations among the staff and families were most positive. This PCC was described as a "beleaguered outpost in enemy territory." To some extent, but not as much so, a supportive, facilitating, external environment seemed to allow more internal dissension.

3. Regardless of the extent of external or internal conflict, the relationships between the staff and the children were never affected, according to the ratings of the field research associates. Without exception, these relationships were described as "exceptionally warm, open, friendly, cooperative, trusting, and supportive." Relations between staff and parents were rated almost as positively with only eight of the 26 centers rated in the second rather than the most positive category. What conflict there has been among the staff of the PCC's, then, does not seem to have had an impact on the quality of interaction between the staff and families and children.

TABLE 12

PCC External Relationships

	Mean Rating	1	2	3	4	5	6
Target Area Community	1.9	13	7	0	2	2	2
Larger Community	2.5	5	10	4	3	2	2
OEO	2.4	7	7	5	5	1	1
CAA	2.8	9	2	2	11	2	0
NSP or Delegate Agency	2.2	10	7	3	4	1	1
Public Health or Medical Service	2.6	9	5	3	6	3	0
Welfare Department	2.9	3	5	8	5	2	3
Public Schools	1.8	13	4	7	1	0	1
Other Agencies (Specify)	1.1	7	1	0	0	0	2

1. Eager to cooperate, share goals, resources, mutually facilitating
2. When problems arise, solutions are sought, and resolutions are made without impairment to program.
3. Little contact, relations, or communication
4. Some resources withheld, some unresolved problems, or some aspects of PCC program affected
5. Many unresolved problems or disputes, program seriously blocked or limited
6. Insufficient information available

TABLE 13

PCC Internal Relationships

	Mean Rating	1	2	3	4	5	6
Between Members of the Policy Advisory Committee	2.0	7	13	3	0	2	1
Between Policy Advisory Committee and Staff	2.4	7	10	4	2	3	0
Intrastaff							
Administrative, Professional	2.1	10	8	3	2	2	1
Professional-nonprofessional	2.6	7	9	3	5	2	0
Nonprofessionals	2.5	6	13	0	5	1	1
Paid Staff and Volunteers	1.9	7	10	1	2	0	6
Between Staff and							
University Affiliate	1.8	11	4	2	4	0	5
Consultants	1.8	11	4	2	4	0	5
Field Research Associates	1.8	15	6	2	2	1	0
Visitors	1.2	16	6	0	0	0	4
Parents	1.3	18	8	0	0	0	0
Children	1.0	26	0	0	0	0	0

1. Exceptionally warm, open, friendly, cooperative, trusting, supportive
2. Generally warm, cooperative, tolerant
3. Business-like, matter of fact, routine relationship
4. Competitive, bickering, pressured, fearful, defensive, anxious
5. Mutually isolating, hostile, highly resistant, rejecting
6. Insufficient information available

SUMMARY AND RECOMMENDATIONS

Summary

By the end of 1969, the 35 Parent-Child Centers were staffed by 751 paid employees, of whom 53 were paid by other agencies and were part of the local matching contribution of communities. With a total of 1818 families enrolled, there was a ratio of one staff member to 2.4 families although this ranged widely, depending upon the center. Eighty-six percent of the staff were women, although all but four of the centers employed at least one man. Most staff were young.

Forty-two percent of the staff are Black, seven percent Mexican-American, 36 percent other Caucasian, and five percent American Indian. Three percent of the staff did not report ethnicity, and the other seven percent are scattered among all the other ethnic groups.

The Parent-Child Centers have provided jobs for 452 residents of the target neighborhoods. Included in this number are 146 parents and other relatives of the children enrolled at the centers. Nearly all the target area employees, like the staff as a whole, are women. The educational range of the PCC staff is broad. While 15 percent have less than eight years of education, and 28 percent have less than 10 years, 22 percent have college degrees, including the eight percent who also have a graduate degree. While the overall ratio of professional to nonprofessional staff is one to four, the range is very broad. Eight centers are essentially all nonprofessional with the exception of the administrators of some of these centers. But at ten centers, at least a third of the staff is professional. While professional staff is more widely available in cities, all urban areas have not employed professionals. The rural PCC's have developed innovative ways to attract professional staff for their centers; these include recruiting returned Peace

Corps and VISTA volunteers, sharing professional staff with Head Start, and recruiting married women with professional experience who could work only part-time.

The training provided nonprofessional staff prior to beginning service has varied widely, but most centers have provided between one and four weeks of preservice training, and have utilized university consultants as lecturers as well as planners of this training. Project Advisers and University Affiliates have played key roles in many of the training programs. In part because of the high rate of staff turnover (27 percent), nearly a third of the staff currently working in the Parent-Child Centers report that they received no training prior to service. In-service training is similarly varied. Some centers have no regularly planned program for in-service training. At others, in-service training of the staff is the major thrust of the program, involving up to 30 percent of all staff time. In addition to training the PCC staff, some centers are serving as field placement sites for medical, social work, psychology, and education students.

The quality of training can best be summarized as uneven. At some centers training programs were well planned and carried out and content was related to later tasks. At others training was a way of keeping nonprofessional staff busy until facilities were ready for service. At still others, training existed more on paper than in practice. It is difficult for centers to provide preservice training to new staff once the program has begun operations. The unevenness of the training, the amount of turnover and the difficulty of providing training while running a program would all indicate the need for some method of training outside of the PCC itself.

The staff of the PCC's report that about half of all time is spent in direct services to children and families, the rest in meetings, report writing, and administration. More direct services are provided when the director of the individual PCC has a degree in education rather than in social work, and when the program is mainly center based rather than home based. Children under the age of three are the most frequent recipients of staff services, and these are most likely to be day care, play groups, or infant stimulation. Older children and mothers are the other main contacts of the staff, and the most likely services are those aimed at meeting their physical needs: food, clothing, housing assistance, or transportation to services.

Even though the field research associates are almost unanimous in stating that the staff of most centers needs more supervision and direction, nearly all state that the nonprofessionals have shown the greatest gains of anyone participating in the programs. One after another of the field staff pointed out changes among the aides in appearance, self-concept, and sense of purpose. These changes are described by one of our field staff:

> The aides gained a great deal from the program. It provided them with employment and a sense of satisfaction in their being able to help persons so obviously in need. The concepts they learned in their in-service training experiences were also helpful to them in working with their own children. Certainly they have been an enthusiastic and hard-working group dedicated to the goals of the agency and to the promotion of a better life for all of the people in the area.

Another pointed out the increased respect the aides were shown by the community after employment by the PCC and the effect of this respect on the staff, and summarized the change by saying, "In short, people who work in America feel better about themselves than people who don't."

Recommendations

Although the kind of service delivered to families is affected by national policy, by the Policy Advisory Committee, by the assets and limitations of the community as well as the physical facility, in the end it is the staff who implements the program. It is therefore not surprising that more comments and recommendations were made by our field associates on the staffing of the Parent-Child Centers than in any other area. The purpose of these recommendations, like the purpose of the evaluation as a whole, is not to criticize what has happened, but to utilize information to help in making more relevant policy decisions in the future. While many suggestions have been made about the selection, training, and supervision of target area residents as staff, these recommendations must be viewed in the framework of the overall observation that these are the very people who have benefited most from the PCC program. The recommendations are made with the goal of being able to extend these benefits to the parents who are not employed as staff as well as to the ones who are.

Management

1. Set job requirements for directors to include education, and prior experience in both program development and administration.

2. Provide project directors with training in program management, fiscal planning and management, record keeping and data collection.

3. Allocate budget to provide project directors with an administrative assistant or a trained and experienced secretary.

Employment of Nonprofessionals

1. Select as aides, people who have the most potential for training and learning rather than those who have the most need for the job.

2. Provide all nonprofessional staff with written job descriptions.

3. Continue to attempt to define nonprofessional roles for men in the PCC's and to recruit men for these positions.

4. Provide within the PCC budget, social work services and professional support for those staff members employed from among the client population.

Staffing Model

1. To the maximum extent possible, the staff of the Parent-Child Centers should be interdisciplinary and should include a social worker, a nurse, and a teacher or child development specialist.

2. The nonprofessional worker should be a part of a team with his professional counterpart, and together they should provide service to the children and families.

Training

1. Training within the PCC should begin with management training for the director and professional staff.

2. Nonprofessional staff should receive orientation to work habits including punctuality, responsibility, accountability, and regularity.

3. If specialized roles have been defined for the nonprofessionals, training for these roles should be provided. The content of training should be different for social work aides, teacher aides, or health aides.

4. Given the cost of training within the PCC and the rate of staff turnover, maximum use should be made of training outside of the PCC.

CHAPTER VI

THE FAMILIES SERVED

THE PCC CRITERION

> An outreach recruitment and admissions process which would guarantee that selected families are economically disadvantaged.[1]

This was the criterion specified for the recruitment of families. Guidelines also recommended that the centers be planned to serve about 100 children under the age of three and their families. As experience has shown, this would mean about 70 families per center, since at the time of enrollment the average PCC family has 1.42 children under the age of three years.

NUMBERS OF FAMILIES

At the present time the Parent-Child Centers have an overall average of 53.5 families enrolled. From the very beginning centers were planned to serve a varying number of families depending upon the location of the center, the resources available, and the major emphasis of the program. The number of families actually enrolled has varied further from the original proposals submitted, and this variation seems to be related to the experiences the centers have had in serving the families rather than to the number of months centers have been operating. Table 14 shows the number of months each of the 34 centers has been serving families, the number of families currently enrolled, and the number of families enrolled to date. This table indicates that those centers which have been in operation less than a year are serving an average of 52.8 families, and that those centers serving families for more than a year report an average enrollment of 54.4 families. While the centers operating less than a year are disproportionately influenced by the center

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 4.

TABLE 14

Number of Months Families Enrolled and Number of Families Enrolled

Number of Months Families Served	Number of Families Currently Served	Total Number of Families Enrolled to Date[1]
4	19	19
4	27	27
4	56	57
7	50	55
7	64	64
7	39	39
8	90	99
10	37	48
10	145	171
11	40	40
12	14	18
12	74	127
12	32	60
13	47	47
13	70	75
13	75	103
13	59	65
13	55	66
13	55	88
14	37	59
14	52	73
14	40	51
14	36	49
14	44	77
14	45	55
15	71	98
15	47	71
15	46	78
15	83	55
16	55	86
16	39	80
16	64	85
17	36	45
17+	75	129
Average 12.1	Total 1818	Total 2426
	Average 53.5	

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[1] See Appendix B for information on the 608 families terminated.

which has enrolled 145 families, examination of the centers serving families for more than 16 months shows that they have an average enrollment of 53.8, or just about the overall average. It would therefore seem that the Parent-Child Centers, as presently funded and organized, are likely to continue to serve an average of 53.5 families rather than the 70 anticipated by the program planners.

The number of families served is only partly related to the length of time in service; as can be seen on the table, one center with only 14 families enrolled has been in operation for 12 months. Another with only four months in operation had enrolled 56 families. Enrollment was higher in rural areas: the 11 rural centers enrolled an average of 62 families and the 23 urban PCC's an average of 49 families.[1]

To understand why the Parent-Child Centers have not enrolled the number of families they initially anticipated serving, it is necessary to take into account the organizational difficulties encountered when the centers attempted to coordinate local resources and to find facilities adequate for infants and toddlers, as well as to understand the characteristics and the life styles of the families the centers reached out to serve.

In this chapter we attempt to describe the methods used to enroll the families, the demographic characteristics of the families enrolled,[2] and the life circumstances of the various groups of Americans who compose "the PCC families."

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[1] We refer always to the number of families "enrolled" since, as will be discussed later, some families are terminated without ever being served.

[2] See Appendix B for a complete tabulation of the demographic characteristics of the families enrolled.

RECRUITMENT OF FAMILIES

The way in which the PCC's went about recruiting families depended upon local conditions, the plans originally proposed by the PCC, and the size of the community. Though there is no shortage of poor families, a number of problems had to be solved in the recruitment process.

--In two urban centers the original proposals called for matched samples of families for control groups. This necessitated extensive canvassing, interviewing, and screening of eligible families in order to select two groups for one center and the three matched groups proposed by the other.

--In a rural center the families were so isolated and were so suspicious that many, many visits and much patience had to be exercised before some families could actually be enrolled.

--In one city the area selected for service was designated as an urban renewal site by the Model Cities program. As a result of the renewal programs initiated between the time when the PCC was planned and when implementation and recruitment of families began, many of the eligible families had been relocated out of the area. The center has never succeeded in recruiting the number of families planned for. Recruitment of enough families has also been a problem in other urban areas.

--Several centers found that the families recruited during the planning period were no longer eligible once the program was funded because the youngest child had passed the age of three and sometimes even four. These centers had to seek new families.

--The original plan in one center was to recruit a few families and then have these families recruit others. However, as our field staff writes:

> The families with which the PCC project began were of little help to the staff in the recruitment of other families. The staff found them to be shy, reticent, and withdrawn from activities in the community at large and from one another. The recruitment drive was also difficult because the staff was determined to reach the families most in need. But they found such families to

> be frightened by contacts outside the family and reluctant to get involved with the program. As might be expected, most potential PCC families were new residents in the community who were either unemployed or underemployed. Considering the city's excellent employment opportunities, unemployment was a clear symptom of basic family deficiencies in job skills, health, and motivation.

Fifty-nine percent of the families now being served were recruited by door-to-door canvassing. Nine percent were referred by other agencies and 23 percent were recruited by some other method; in some areas this other method was the referral of one family by another. In some centers up to half of the families were referred by other agencies, mainly the welfare department.

Criteria for eligibility of all centers included a child under the age of three years and a low income for the family, but some centers established unique criteria. For example, one rural center specified two-parent families with no more than five family members. Four urban centers developed special programs for teen-age mothers. Two rural PCC's both gave preference to working mothers. These special selection criteria naturally cause the demographic characteristics of the families to differ from center to center and must be considered as the data from the centers are discussed in the following section.

CHARACTERISTICS OF THE FAMILIES

That the poor are not a homogeneous group is fully confirmed by the data on the 1,818 PCC families[1] provided by the centers as well as by the observations of the field staff. Enrolled in the Parent-

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[1] Data on the demographic characteristics of the families have been processed from the Family Intake Records completed by a PCC staff member for each family enrolled at the PCC. The problems involved in securing these data and the inaccuracies believed to have been reported are discussed in the Methodology chapter. The problems are not reiterated here, but caution in the interpretation of these data is urged. See Appendix B.

Child Centers are diverse groups of families whose characteristics vary as widely as do the locations of the centers serving them. Aside from the shared criteria of a low income and a child under the age of three, there is little similarity in the life conditions, style, problems, or strengths of the young, Black mother in Newark, Chicago, or Louisville, and the Thlinget Indian mother who works in the fish cannery in Hoonah, Alaska. The Hawaiian mother displaced from the island of her ancestors to a high rise, low-cost public housing project in Honolulu faces very different circumstances from the 22-year-old White mother of six children married to a man three times her age--a man who raises tobacco in the same plot of Kentucky soil as his father and grandfather.

The families differ not just by geographic location and ethnic grouping for within any one center or any one ethnic group there is a great range of family characteristics. Some of the diversity and some of the groupings are indicated by the demographic data, some only by the more qualitative observations of our field staff. In this section, we attempt to describe the differences and the similarities of the families served.

Family Composition

There is a wide range among the centers in the number of families with a father, stepfather, or foster father reported as the head of the household, and this range depends in part upon the criteria established for selection of PCC families, on the location of the center, and on the ethnic composition of the families enrolled. Fifty-eight percent of all PCC families are headed by men, but the range is from a low of 20 percent in two centers to more than 75 percent in 11 centers. In the rural center which established two-parent families as a criteria for selection, 93 percent of the families have a father in the home. On the other hand, those urban centers with special programs for unwed teen-age mothers, by definition have more families headed by women.

Location of the center seems to be a major determinant of whether families are headed by men or women, for of the 11 centers with more than 75 percent male heads of household, ten were rural centers, and only one center is urban. Location of center cannot be separated from ethnicity, since, as will be discussed later, the rural centers enrolled mainly Mexican-American, other Caucasian, and American Indian families, whereas the urban centers primarily enrolled Black families.

There is a mother in the home of all but six of the PCC families; three of these families are enrolled in three sites of the one rural American Indian center.

The size of the family as well as its composition is also related to the geographic location. While the average family size reported is 5.7 members, rural families report an average of more than six members. To be eligible for the PCC, a family must consist of at least two members--a parent and a child, even if the child is unborn; only five percent of PCC families are this small. Thirty-two percent report three or four family members, but 22 percent report eight or more people in the family. The average number of children reported by PCC families is 3.6; this ranged from a low of 2.1 children per family in a west-coast urban center to 5.0 in one in the rural South. The number of children these families have is very high in the light of the fact that more than 20 percent of the mothers are under 21 years of age and probably will give birth to more children.

About one family in five is an extended family with relatives other than the parents and children living in the home. These extended families seem to be just as common in rural as in urban areas; however, these families are qualitatively different, and these differences have program implications. In urban areas, many of the PCC mothers are young and still living in the home with their own parents and siblings. In the rural areas, a grandparent or other adult relative is more apt to live in the home with the parents of the PCC child. An example of an urban family where the PCC mother lives with her mother is reported by one of our field research associates:

> Miss G. is only 19, spirited, attending high school, and with a definite career goal in mind--that of becoming a nurse's aide. She wasn't in school the day I visited because her two children, ages two and one, were awake until one in the morning and she didn't wake up in time. She lives with her mother, a jovial, outgoing, grossly overweight woman in her fifties. She kidded about the nurses trying to take her into the delivery room when her daughter went into the hospital to have her last baby. The other children, Miss G.'s siblings, were in school that day.

Contrast this with a family from a rural center in which the grandmother lives with the PCC family:

> The father is 35 and the mother is 22. There are three children between the ages of one month and 30 months. The father is a milker and they live in a house furnished by his employer. It has no bathroom facilities. The grandmother, the mother of the father in the family, came to live with them last year when her husband died.

Though only one PCC family in five report relatives other than the immediate family living in the home, those who do are apt to have several relatives, for the 364 extended families have a total of 958 people living with the nuclear family. These relatives are most often grandmothers or other female relatives, but male relatives are only slightly less frequent. We have no information on the data forms about who these male relatives are and it can only be assumed that while some are brothers or uncles of one of the parents, some may also be men acting as spouses. As is characteristic of the life span of Americans in general, the women live longer than men, so that while 13 percent of the relatives living with the PCC families are grandmothers, only seven percent are grandfathers.

Focal Children

Of the 2,585 focal children enrolled in December of 1969, 51 percent are boys, 47 percent are girls, and three percent were unborn at the time of intake. Nearly two-thirds of the PCC families have only one child enrolled at the center, 28 percent have two children, six percent have three children and one percent have four or more children. One family with two sets of twins has five children under the age of three enrolled, although our coding categories do not allow for this unlikely possibility. The average family enrolled in a PCC has 1.42 children under the age of three years.

The mean age of the children at the time of enrollment in the different centers varies from a low of 9.7 months to a high of 35.7 months. The overall mean age at the time of enrollment is 19.4 months although 36 percent are over two years when accepted. Age is not reported for one percent of the children enrolled.

Our field staff report that when they first visited the centers and the homes of the PCC families, most infants and toddlers were left to lie in their cribs most of the day. Mothers were too tired and depressed to take the children out even to feed them, so that the babies very early had to learn to find the nipple of the bottle propped beside them. Crawlers and toddlers could not be let out of cribs (or sometimes boxes) because the floors of the homes had broken boards and splinters, and were a hazard to young children. For some the only warm place in winter is in bed with several other children and the mother. Crawling and exploring the environment is just not possible in many of these children's homes. For some, the PCC is the only place with running water, or water warm enough to bathe the babies and toddlers during the winter. Several centers have instituted a bath as part of the morning procedure when the babies arrive at the PCC.

One field associate after another commented on the extreme passivity of many of the children at an age when curiosity and exploratory activities are usually at their peak. For example, at one rural center, an eight-month-old child was observed to sit in a canvas jump seat and stare with little or no facial expression or activity for over an hour. Staff of many centers reported that many of the children and even their parents hid when first approached by PCC workers. The differences between these infants and tots and others their age were commented upon by nearly all of our field staff.

Additional comments comparing PCC children with others are presented in the later chapter dealing with developmental examinations (Bayley tests) of children.

Ethnic Composition

Important to any discussion of the ethnic groups served by the Parent-Child Centers is an understanding of some of the important factors influencing patterns of racial distribution in the United States at the present time. Most of the poor live in urban areas, and in large urban areas most of the poor are Black. While integration is a goal still being pursued in the South, it is not a goal in most northern ghettos. That 47 percent of the families enrolled in the PCC's are Black is influenced by the fact that 25 of the 36 PCC's are located in urban areas. Table 15 shows the percentage of total PCC enrollment in each ethnic group and the rural-urban distribution of these enrollees.

While the four major ethnic groups, Black, Mexican-American, other Caucasian, and American Indian account for nearly all of the enrollment of the PCC's, their distribution varies widely with geographic area. Though at least one Black family is enrolled in 29 of the PCC's, only five percent are enrolled in all of the 11 rural PCC's. The Black families are overwhelmingly urban.

American Indian families, including the Oglala Sioux, the Menomonie, St. Croix, Chippewa, and Thlingets are mainly rural; only eight percent live in urban areas. The Mexican-American families are mainly enrolled in two urban and two rural centers, but 71 percent are at the rural centers. Caucasians other than the Puerto Ricans and Mexican-Americans account for 27 percent of the PCC enrollment, and 69 percent of these are in the rural centers. Less than five percent of the total PCC enrollment are other Caucasians in northern urban centers; that is, the White families enrolled in the PCC are either rural, or if urban, are southern.

TABLE 15

Ethnic Characteristics and Location of PCC Enrollees

	Percent Total Enrollment	Percent Rural	Percent Urban
Puerto Rican	1	4	96
Mexican-American	8	71	29
Other Caucasian	27	69	31
Negro	47	5	95
American Indian	11	92	8
Polynesian	2	0	100
Oriental	0	0	0
Eskimo	1	100	0
Other	2	37	63
Not Reported	1		
	100%		

In addition to the four major ethnic groups discussed, the PCC's serve the multiracial population in Honolulu and Eskimo families in Alaska.

In the PCC's in the South, integration was established as a goal, and all but one southern center have succeeded in recruiting and maintaining both Black and White families. The one which has not yet achieved such an enrollment reports that it has set integration of the PCC as a second-year goal. Most northern PCC's have accepted the pattern of residential segregation and have not made any attempt to integrate the PCC. In fact, many have made deliberate efforts to employ mainly Black staff and to enroll Black families. This policy is in keeping with the strong movement for self-determination prevalent in northern ghettos. Of the 13 PCC's where more than 85 percent of the families enrolled are Black, 12 are in northern urban ghettos. Only three of the northern urban PCC's have recruited families from several ethnic groups.

Age and Education of the Parents

As might be expected of parents with children under three years of age, 68 percent of fathers and 77 percent of mothers were under 35 years of age. Only four percent of the fathers, and five percent of the mothers were over 50. Except for this slight variation, the ages of the parents were in keeping with general expectations in the United States in that the fathers were older than the mothers. While 32 percent of the fathers were reported to be over 35, only 12 percent of the mothers were. At the time of intake, six percent of the fathers and 21 percent of the mothers were reported to be under 21.

While there were young mothers reported from most centers, they were naturally more heavily concentrated in those centers which developed special programs for teen-age mothers. These young mothers also tended to be more heavily concentrated in the urban centers of the North with heavy or entirely Black populations.

As is generally true of this population, the mothers are better educated than the fathers, although both parents have a lower than average educational achievement. Thirty-nine percent of the fathers and 28 percent of the mothers have eight or fewer years of education. For both fathers and mothers, 22 percent have completed high school and four percent have attended some college. One percent of the fathers have completed college. This limited education is particularly striking considering the youth of most of the parents.

There was great variation between centers in the educational level achieved, and this variation is related to both geographic location and the ethnic groups likely to be served by the particular location: the families enrolled in the urban PCC's tend to be better educated than most, and since most of the families enrolled in urban PCC's are Black, the Black families are better educated. The highest level of education reported by the Black mothers was in one urban center, where 79 percent of the mothers had completed high school; of these, 37 percent attended some years of college. (The field research associate confirms that these mothers appear to be quite well educated.) The lowest level of education is reported by one rural center where 86 percent of the fathers and 79 percent of the mothers have eight years or fewer of education and only three percent of the fathers and 11 percent of the mothers have completed high school. Almost as poorly educated are the Mexican-American parents in another rural center where 78 percent of the fathers and 76 percent of the mothers have eight or fewer years of education. Here only one father and three mothers report that they have completed high school. The American Indian parents enrolled do not appear to be as well educated as the parents in many of the urban Black centers, nor as poorly educated as the Mexican-American and rural Anglos. While 44 percent of the fathers and 43 percent of the mothers on the reservation report completing eight or fewer years of education, 26 percent of the fathers and 21 percent of the mothers report high school graduation or more.

Income

The income of the PCC families reported directly by the centers is so incompletely and inaccurately reported that no interpretation should be attempted. Income was not reported on the Family Intake Record for 33 percent of the families; the percent of families for whom no income was reported ranged up to 67 percent in one center. The reasons why this information was not reported, as given by the PCC staff members, are many and varied. Many of the PCC mothers are young girls who live with their parents, they report that they do not know the family income, and the PCC staff did not attempt to acquire the information from the grandparents. In another PCC where 59 percent did not report income, many of the families had income from a variety of sources: wages, government allowances, leased land, and veterans benefits. Reporting this income on an annual basis would have required a tally of income from all sources. In one urban center the mothers reported that their husbands did not tell them how much money they made and so they could not respond to the question on income. In most urban centers there was enormous hostility to answering the question on income from both PCC staff and families. In some there was concern that the information might be conveyed to the welfare department. Many felt that their poverty was evident and didn't need to be validated.

It is impossible to estimate what effect the absence of information on a third of the families has on the overall income data reported. It could be that many of the families who did not report income were over income and that is the reason why the information was withheld. It could also be that their incomes were so low that they were embarrassed to report how poor they were. There is simply no way to guess the implications of the absent information.

The only thing that can be said about the income data of the PCC families is that for the two-thirds who responded, the mean per capita income was $417. Of those who responded, 41 percent reported

Occupation and Employment

Of all the PCC families currently enrolled, 1,057 report a father living in the home; of these 72 percent report that they were employed at the time of intake. Of the 26 percent unemployed, the largest group, 35 percent, report that they could not find work; 24 percent report ill health as the reason and 27 percent cited some "other" reason. It is reported that only three percent did not seek work. The highest unemployment rate reported is in an Appalachian area where 59 percent of the men were unemployed when accepted by the PCC. Nearly as many, 55 percent of the fathers living on an Indian reservation, were also unemployed. In four urban centers, more than one-third of the fathers were unemployed. Less than half (49 percent) of the fathers reported that they had worked all 12 months of the year prior to acceptance to the PCC, and another 20 percent worked between seven and 11 months. One-fourth worked less than six months the previous year.

The majority of the fathers who were employed reported their occupations as laborers, 37 percent, and other service workers, 30 percent. No occupation was reported for 11 percent, and fewer than five percent were employed in scattered occupations of sales, operatives, farmers, armed services, students, and craftsmen.

Since most of the Parent-Child Centers specified participation of the mother as a criteria for acceptance, it is not surprising to find that only a total of 251 mothers, or 14 percent, report being employed. Of these, 97, or 38 percent of all working mothers, are employed in the PCC itself. It is also not surprising that the centers that provide day care have the highest rate of employment of the mothers since day care for their children is often a prime determinant of whether or not a mother can work. Only six percent of the mothers reported that they had worked for all 12 months of the year prior to PCC acceptance.

an income under $2999 a year. The income reported for 28 percent was between $3000 and $4999, for 12 percent it was between $5000 and $7999 and less than two percent reported more than $8000 a year.

Welfare Status

Forty-two percent of all PCC families report that they were receiving welfare benefits at the time of intake, five percent did not respond, and 53 percent reported that they were not receiving welfare. Thirty-three percent of the rural families and 48 percent of all urban families report receiving welfare: in ten urban centers more than half of the families reported receiving welfare. One center precluded the likelihood of many welfare recipients since it specified that to be eligible for the PCC, families had to have two parents, and that state does not ordinarily provide welfare benefits when there is a father in the home.

Housing

In no other area do statistics mask the grim reality of the lives of the PCC families more than they do in describing the housing of the families. Nearly all of the 19 percent of PCC families who own their own homes live in rural areas, and most of the 14 percent of families who do not have running water in their homes are enrolled in the centers where there is a high rate of home ownership. To say that more than 69 percent of families in three rural areas live without running water does not carry the full impact of what it means to families to live without running water in an age when men land on the moon. The reports of some of our field staff help make clear the enormity of the effect on daily living. From one center, it was learned that when the PCC first opened, many of the children came to the center not just dirty, but dirt encrusted, for when the streams froze in the winter, the family was unable to do laundry for weeks on end. The aides have instituted a regular schedule of picking up the mothers to take them to use the laundromat in town. Nearly half of these families own shacks down in the "hollers" of this hilly and rugged country. The houses are not likely to instill "pride of ownership" in anyone.

From another rural center the FRA reported that many of the families lack not just running water, but even an outhouse. Another field staff member wrote, following one of her visits to a Parent-Child Center:

> ...the aides reported...a sewer broken and running under the house, a family of eight living in two rooms with no sink or drain or working refrigerator. Another family with ten children had no water at all in the house; their mother had to go to the brook to get it, and there was a problem of using a right of way to water coming from a spring. A family was living in a place full of holes with poor heat; kids were shooting rats with a BB gun. A number of houses had no running water or indoor bathing facilities (and for weeks on end in the winter the outdoor temperature does not get up as high as zero degrees).

Again, from a rural center:

> The house, (if a tar paper shack set up on bricks with plastic sheeting over the window holes could be called a house) was on the edge of a stream. Two unbelievably white children were throwing pebbles into the water while their mother boiled what I took to be the week's laundry in a tub in the yard. The grandmother sat on an unpainted wooden stool under a tree; she had a single lower front tooth, against which she rubbed her tongue as she nodded her head. A man, whom I assumed to be the father, lay inside the house on a dirty mattress with no bed covering.

Many of the families enrolled in another Parent-Child Center live along the banks of a river which floods the houses twice a year; this is the only running water the families have.

It is not just the residents of rural areas who must contend with dilapidated housing conditions. Although most of the urban poor who rent their homes have running water, many live in tenements in which the bathroom down the hall is shared with three or four other families--when it is stopped up, the gas station down the street must be used. From center after center our field staff report that the floors of many homes are so broken or so splintered that infants cannot be put down to crawl.

Again, a field staff member reports:

> Mrs. M. lives in a ruin of a house amid ruins of other houses. The house next door is empty, all of the doors and windows are smashed in, and it leans ominously in the direction of the M. home.
>
> The porch of the M. home is littered and several boards are broken through....Upon entering we were met with a strong odor of mixed origin: urine, dogs, past cooking, rotting boards, and who knows what else. The walls were bare with plaster in some places, there was a small rusty heating stove, and not one piece of intact furniture. Overstuffed chairs had partial cushions and gaping holes in their backs or arms.

Thirty-nine percent of PCC families report that they live in public housing. More than half of the families in eight urban and two rural centers live in public housing. Though public housing is almost always better maintained than homes owned by the desperately poor, housing projects are not without their own problems. The families in one housing project are unaccustomed to high-rise dwellings, and children have fallen to their deaths from the unscreened balconies. Fear of teen-aged gangs in the project is a concern of other PCC families in public housing. What many PCC families who live in housing projects mind the most, however, are the many limits and restrictions placed on them and the sense of powerlessness in relation to the city or the housing authority.

Differences Between the Families Served

The demographic data make it clear that a wide range of families are served; what statistical data do not make clear are that some families who share characteristics of location, ethnic group, income, educational level, or housing conditions may in fact be more different than they are alike. These differences have been described in a most poignant way by one FRA in an early report from one of the centers:

> At one point in our tour of homes, the social worker brought me to a spot where anyone would have to acknowledge the existence of a basic dilemma facing poverty programs such as the PCC. Within sight of each other, there were two trailers occupied by Caucasian families enrolled in the PCC. They represent a beautiful example of how different people in the same economic circumstances can be. The difference in these two trailers certainly makes one wonder if poverty is the true obstacle which these people must overcome. Neither family was at home when we arrived, but one did not have to go inside the trailers to see the enormous difference in the life styles of these two families.
>
> Both trailers were vintage 28-footers. One, however, had broken windows, paint so flaked as to give a speckled appearance, and was set on a lot overflowing with various kinds of junk and garbage. The only attractive feature in the whole scene was a pair of puppies. They were too young to have their appeal marred as yet by the hand of a negligent master. Outside the door of the trailer was an old, wringer-type washing machine. On looking inside, my eyes were greeted with a sight of children's shorts and shirts soaking in filthy greyish water with scum on the top at least one-quarter inch thick. The social worker reported that the stench inside the trailer was beyond description.
>
> The other trailer was literally within a stone's throw. The human distance, however, was more nearly interstellar. This trailer was an attractive shade of brown, obviously home painted. The yard was neat, clean, and equipped with a relatively new child's swing and seesaw. The trailer was parked under a tree, from which the owners had hung some planters whose flowers were then in bloom. Behind the trailer, the property had been fenced in. In this area two lines of freshly laundered sheets and

> clothes were hanging out to dry. The social worker reported that the mother was an immaculate housekeeper.
>
> Both families have four children. The father of the first family had just been released after serving a six-month sentence in the county work camp for driving under the influence of alcohol and a few compounding specifications. The social worker reports that he is again driving, but without benefit of a license. He is unemployed, and has been extended credit at the grocery store. On the other hand, the father of the second family increases the income from his regular job by driving a bus for his church. Also, the trailer in which he houses his family costs approximately half what the first man is paying for his trailer.
>
> The disparity in the actual life-styles of these two families who will otherwise appear comparable on the basis of government-collected statistics is a factor which programs like the PCC cannot afford to neglect. The potential for change and improvement in these two families is obviously discrepant. It is most doubtful that any one program will have comparable success with such heterogeneous clients. Thus, PCC staffs should be encouraged to analyze the reasons for their failures as well as their successes. They should not be led to feel that all failures are their fault. Otherwise, they may conveniently confine their selection of clients to those with the most promise for responding to the type of program they are presently able to offer. PCC staffs may also begin to camouflage the real reasons for families leaving the program, if there is no acknowledgment that some cases may be too difficult to reach with present offerings.

Differences among three urban families have been described by one field associate who says, "I describe these families not to be dramatic but because I don't think it is possible to get the full impact of the situation facing the PCC without understanding the families environmentally as well as psychologically."

> 1. Miss L. is 22 years old, has three children ranging in age from two to six years. She lives with her mother in a small well-furnished, clean, and very attractive house. Miss L. has a serious speech impediment and because of it gives the impression of being mentally

retarded; whether she is, the staff did not seem to know. The mother as well as the PCC staff would like the children to get into day care; however, since the three-year-old is spastic and cannot walk, this presents a problem.

2. Miss E. lives in a deteriorated row house but the apartment itself is bright, clean, and well furnished. This mother is only 21 but has two sons, one five and one a year old. Miss E. says that she receives only $105 a month AFDC payment which is not sufficient to pay the rent and feed the children so she would like to go back to work. She is a high school graduate with typing skills and the desire to be an office clerk. She had worked previously as an elevator operator, but says that she had to quit because of baby-sitter problems.

Miss E. is hoping that the PCC will provide day care for her so that she can get back to work. She conveys a kind of desperation when she talks of needing a job and above all else of needing to get out of the house and be with some friends.

3. Unlike the two young girls I visited first, Miss S. is a 39-year-old woman with five children ranging in age from two years to fifteen; all the children have different fathers. The baby is thought to be retarded. The aide has been bringing blocks, colors, and toys for the baby to play with.

The family has been moved by the PCC to its present apartment which is said to be a vast improvement over the previous one, although the building is dark, smelly, and littered.

The mother seems to have above average intelligence although she only went to the eighth grade in school. The PCC has been trying to get her to enroll in adult education classes, but it never quite works out, and she always has some excuse why she does not get there.

On the day I visited, none of the children were in school, and the mother said, "Oh, we weren't feeling too well and just overslept. It's my fault, I should have got them to school."

> She sometimes leaves her children for several days at a time, but returns to them when her mood has spent itself. Miss S. talks with a friendly, accepting passivity about her life situation. The PCC has tried to get her to go to school, to do day work, to look for a job, but Miss S. never quite manages to meet the expectations of the PCC.

The cases have been reported to illustrate the fact that the PCC families differ not just between areas, ethnic groups, and age groups, but within any one group or area the needs encountered vary widely and necessitate vastly different intervention strategies. After reading a variety of reports from our field research associates on the PCC's, Dr. Lois Murphy wrote:[1]

> I don't see how, for instance, people who have never worked first-hand with persons from the extreme poverty group, can possibly realize the size and character --the incredible enormity of the task which has been set. For generations, if not for hundreds of years in this country, it has been assumed that everyone has the opportunity to make his life better and that, as far as external circumstances are concerned, it is easily possible for anyone to be mobile, either in terms of horizontal change from one part of the country to another to achieve greater comfort or satisfication, or of vertical change to a "better" economic, educational, or vocational situation. The fact that any combination of many, many different factors may interfere with the reality of mobility and the capacity for change is widely neglected. Most outstanding in this neglect is the situation of people such as those in a former mining town in an isolated area. When mines become unprofitable and are shut down--as has happened over and over again in this country--and industry, with all its resources, moves on without taking any responsibility for the men who have been put out of work after contributing to the productivity of the industry (and the country) and are therefore without means to provide for their families, the stage is set for sequences of serious deterioration of human life. In the isolated areas such people may have no other opportunities to turn to within manageable distance, and for many different reasons may not have accumulated resources permitting them to explore opportunities outside of their immediate area or resources

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[1] Report to KAI, June 20, 1969.

to move the whole family to a new area which might or might not give them an adequate vocational opportunity. For these and other reasons that we may not know, but also obvious ones such as illness in the family, ties to relatives and friends, or attachment to the locale (very common in beautiful mountain and forested areas, and rightly so), people may stay put, despite discouragement and frustration. However, as resources continue to dwindle and there is not enough money to feed the family, mothers become undernourished, the babies with whom they are pregnant are prenatally undernourished, there is inadequate care at birth as well as before birth, the children are born vulnerable if not outright damaged, and "the stock" becomes less hardy than it was to start with. Without adequate food to provide energy, families take less and less adequate care of their habitation, their clothes, and themselves, including the small babies who are getting a start in life. With constant frustration and discouragement, tempers get out of control, angry reactions become commonplace, children learn to keep out of the way, and gratifying communication between adults and children including babies becomes minimal or nonexistent.

Outsiders looking at these hungry, ill-fed, ill-housed, ill-clothed people may react in different ways--sometimes with compassion or pity and an impulse to provide some immediate help in the form of clothes or food; sometimes with disgust and scorn for the disheveled or dilapidated condition of every aspect of life; sometimes with outright hostility and rejection--with such statements as, "If they wanted to they could get out and get a job;" or "If they had any gumption they could do better for themselves."

Such reactions I had heard all my life, along with the idea that "The stock has deteriorated and you can't expect anything much from these people."

This general description applies not only to people in isolated mountain areas but also to those in the South who have been displaced by machinery for handling cotton, and those in certain farm areas who have been displaced by the efficiency and the expense of farm machinery. This process of deterioration of the population is actively going on at present and I have seen directly some of the recent results; that is, first steps which lead to the disorganization which has been taking place for over a hundred years in some of the mining towns.

In view of this condition and the widespread assumption that such people could not change because of intrinsic inadequacy, and also in view of the years or generations of habits rooted in discouragement, frustration, and the natural suspiciousness of a rejecting world, what expectations do we have regarding either the tempo, the means, or the steps in contributing to positive change? Anyone with some years of experience in therapeutic efforts to produce change in people will quickly recognize the enormous differences in the potential tempo of change. Some of these differences have to do with individual constitutional factors which have not been adequately studied as yet by the sciences having to do with human development; some of them have to do with the appropriateness of professional methods used to contribute to change; some of them have to do with the duration and magnitude of the consequences of deprivation and pathology. In these days of instant coffee, instant hot cereal, instant mashed potatoes, the concept of instant production tends to distort our expectations. Moreover, in these days of crash programs which can be applied in certain areas dealing with well-established methods of construction--as with construction of housing and the use of prefabricated parts--and in these days of speedy assembly lines; we have lost sight of the fact that human beings are not part of the universe of machines, but are growing organisms who take their own time. To be sure, new forms of nutrition such as "Miracle-gro" tend to speed up the tempo of growth--but even so it is still true that radishes can be produced in a few weeks while it will still take a few years for wisteria to bloom; and Miracle-gro will not produce strawberries as fast as radishes. Moreover, while antibiotics may cure an illness quickly that is due to bacterial infaction, virus infection have not yet been brought under such control and it is taking longer to discover the chemicals that will be able to effect these results.

Inventions typically take time. Moreover, the payoff for many inventions cannot possibly be measured at early stages of the development of the invention. One impressive example is the fact that it took eight years for the Wright brothers to develop a primitive airborne machine that would stay off the ground for a period of 57 seconds. It could not be imagined at that time that within the lifetime of people who were children at that beginning stage, machines would be under development that would take people across the ocean in three hours.

I am spelling out all these factors in order to indicate the reasons why I feel we have to approach the understanding and study of PCC centers with a long perspective on people. The PCC centers have in many cases been established in areas where misery has characterized life for many years or generations. We have to take it for granted that change will take time, and that it will take time to discover the combination of approaches that will be able to accomplish change in the different settings. The fact that there are so many climatic, cultural, and temperamental differences in the different groups of people in PCC's located in different geographical areas should imply to any thoughtful person that no standard model can be arbitrarily imposed on PCC's with such widely different human problems and situational characteristics.

The time required to effect change may have some relation to the duration of pathology and life difficulties of a given group. The approaches contributing to change will have to vary depending on the wide difference in cultural patterns, motivations, values, interests, and needs as they are felt by different groups.

The question might be raised, would it be worthwhile to try to produce change under such complex and difficult conditions? The answer is that without such efforts we face the fact that our affluent nation is continually producing more physiologically, emotionally, and socially deprived and frustrated and inadequate people who constitute an increasing burden on our society and whose support and control is far more expensive than the costs of reducing this number by any substantial fraction. In other words, economic considerations, quite aside from humane ones, make it urgent to continue working at the problem of how to produce constructive change in people who have suffered so extremely from the irresponsibility of our society which I mentioned before. Aside from current and persistent economic considerations, the country now faces a new generation which is unwilling to tolerate the destruction of human personality and the wasting of potentialities which they can now see directly for themselves due to their own mobility. The failures of American democracy are no longer hidden from view.

SUMMARY AND RECOMMENDATIONS

Summary

Though the 1818 families currently enrolled in the Parent-Child Centers are not a homogeneous group, nearly all are very poor. As a group they have the following characteristics:

--Fifty-eight percent are headed by a father.

--The average PCC family has 5.7 members, but 22 percent have more than eight members.

--The parents are generally young, with 21 percent of the mothers under the age of 21 when first recruited.

--The average family has 1.42 children under the age of three enrolled at the PCC; these children's average age was 19.4 months when first enrolled.

--The major ethnic groups account for all but six percent of the PCC enrollment: eight percent are Mexican-American, 27 percent other Caucasians, 47 percent Negro, and 11 percent American Indian.

--For such young parents, many have a very low educational level: only 22 percent of both fathers and mothers have completed high school. Thirty-nine percent of fathers and 28 percent of mothers have eight or fewer years of education.

--Forty-two percent of all PCC families were on welfare at the time of intake.

--Of those families headed by men, 26 percent of the men were unemployed at the time of acceptance into the PCC.

--Nearly all of the 19 percent of the PCC families who own their own homes live in rural areas.

--Fourteen percent have no running water in the home.

--Though incomes were not reported with a degree of accuracy or completeness that allows for exact reporting, our field staff report that the families enrolled are not just poor, they are in large part among the poorest families in America.

It is important to recognize the characteristics of groups of PCC families, but it is equally important to recognize how the families differ. While many of the families enrolled are the truly "hard core, multiproblem, disorganized" families who traditionally consume the bulk of public social services, some in all ethnic groups and all locations are not. It is important that all not be lumped into one large group for whom a single intervention strategy is developed.

On the other hand, the dominant demographic characteristics of the four major ethnic groups served make it crucial that programs recognize these widely differing types of PCC families. These characteristics include the following:

> --Almost half of the PCC families are Black and the percentage is increasing as more of the urban centers enroll families; nearly all of the Black families enrolled in the PCC's live in urban areas. Most are headed by women who are generally very young. Though not actually well educated, they report many more years of education than do the other families in the PCC.
>
> --Most Mexican-American and other Caucasian families live in rural areas, have two parents, both of whom are poorly educated. The fathers are apt to be employed intermittently at low-skilled jobs. Lack of acculturation describes many of the desperately poor rural Whites as well as it does the Mexican-Americans. The resources of the communities, the employment opportunities, and the housing conditions of both these groups are deplorable.
>
> --Most American Indian families enrolled in the PCC live on a reservation or in a rural area. Most of the families are headed by fathers who were unemployed at the time of intake. The parents report more years of education than do any but the Black families in urban areas. Though very poor, the lack of current income is not as severe a problem as the lack of long-range opportunities for employment.

Recommendations

There are obviously many different types of clientele to choose for PCC's. One can select the most hard-core disadvantaged and disorganized, one can "cream" to work with those who are poor but who are upwardly mobile and have positive attitudes, one can recruit families in-between these extremes, or a mix of types of families. It should be evident that the recruitment and selection process should be one part of an overall PCC strategy. Often, this does not appear to have been the case.

If the most hard-core poor families are selected, it is necessary to provide every conceivable service including funds for food, shelter, and sanitation. In a number of cases, these families have been selected although resources were not adequate to serve them. In other cases, these families were selected and child-oriented programs were not accepted by the parents because the parents lacked the basic necessities to sustain life. In most cases, PCC's have focused on the most destitute and have not "creamed." While this approach may be justified on humanitarian grounds, it does require that the programs offered bear a responsible relationship to this type of clientele. If this cannot be accomplished, consideration should be given to recruiting other types of clientele who can be appropriately served.

CHAPTER VII

PROGRAMS FOR CHILDREN

INTRODUCTION

The third criterion for the establishment of Parent-Child Centers is directed at children's programming: "A program of activities for the children designed to stimulate their physical, intellectual, and emotional development to the maximum potential."[1] The 35 funded PCC's have designed a variety of approaches to meet this criterion. Thirty-three projects report serving 2580 preschool children, while one serves only parents and another has been unable to deliver any services to children or families.

1195 children are provided a center program in 99 groups
700 children are visited only in their homes
181 children are provided day care at the centers
135 children are provided home day care in 42 group homes
2211 total number of focal children

369 other preschool children are served in 34 play groups in 14 PCC's
2580 preschool children being served by PCC's

Types of Programs

The PCC's provide service to children from 6 months to 3 years in the following ways:

16 provide home and center programs
6 provide home only programs
11 provide center only programs
1 provides no children's program
1 has not yet initiated a child's program
35 PCC's[2]

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 4.

[2] A total of 2585 children were classified as "focal children" on the Family Intake Records completed by the centers. Included in this number are the 270 children who were over the age of 36 months at the time of intake and 65 unborn children. Not all families or children who are enrolled are served. This probably accounts for the small discrepancy in the number of children served in programs, and the number of children enrolled.

The philosophies and theoretical framework of the children's programs will be discussed later in greater detail. However, for an overview it is interesting to note that eight PCC's provide a cognitive-stimulation program, 22 provide a developmental-affective approach, and three have combined both types of programs.

In all but nine PCC's, infants were visited in their homes and this was for a variety of reasons:

1. Most center facilities were not adequate for infant's programs because of size, heating, and other safety factors. One of our observers in a northern urban center comments on the facility:

> The infant room is small and shared with the social worker, and her desk takes up most of the space. In addition, the room contains a playpen, one convertible baby carriage which is used as a crib, and a large table. The room also contains several shelves filled with commercial toys for infants and small children. A large table in the room was used to interview parents and the social worker's telephone often interrupted the infants' rest as did the more active children in the play groups next door.

2. It was difficult to bring the infants to the center. In many of the rural centers transportation is not available for mothers living long distances from the center. In addition, when the weather is very cold or hot, even short distances make the transporting of infants difficult for those without cars.

3. Some states prohibit the group care of infants, and many cities have stringently enforced codes for facilities housing infants in group care programs.

4. The problems of caring for infants and providing them with more than baby-sitting services are a reflection of the larger community, in terms of the lack of resources and professional knowledge of the field. The number of specialists for training professionals and nonprofessionals in infant education and care is minute compared to the needs of the PCC's and the community.

5. Group care of infants outside their own homes has been suspect in the United States and this attitude has been reflected in the PCC's in terms of providing home visiting programs for infants. Mary Elizabeth Kiester[1] states:

> We cannot ignore the fact that we have by no means "proved" that care of babies away from their own homes, in groups, is not detrimental to healthy development. There are many among our colleagues who will say that this trend toward group programs will only lead us back toward "the dark ages" of child care...
>
> The attitude generally held by pediatricians, psychiatrists, professional social workers, and by informed parents toward the care of babies outside their own homes is to deplore any plan that involves bringing them into a group for all-day care. These attitudes in part have their roots in the now-classic "Bowlby Report," published some 18 years ago by the World Health Organization. This report summarized studies relating to the long-term development of children reared in institutions, hospitals, or foundling homes, or in a succession of foster homes, studies that seemed to point to detrimental effects of these experiences that persisted, malignantly, into adolescence and adulthood. The conclusions drawn from the studies were (1) that health (and indeed life itself) is threatened by lack of a mother's care in infancy and by even rather short-term experience in the impersonal setting of an institution; (2) that babies above all need to be cared for by their own mothers or by a permanent substitute for her; and (3) that group care *per se* is detrimental to a baby's growth and development because it cannot possibly involve care by one mothering person.
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> Hence over the past twenty years there has been the widespread recommendation that if an infant needed daytime care to supplement that given by his mother,

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[1] Mary Elizabeth Kiester, "A Demonstration Project: 'The Good Life' for Infants, and Toddlers" (Paper presented at a symposium sponsored by the Day Care Council of New York, April 30, 1969), pp. 3 and 4.

> the only acceptable substitute would be another mother who could take the baby into her home for the day or a motherly person who could come to the baby's own home to care for him on a rather "permanent" basis.
>
> In more recent years, this view of "maternal deprivation" has been refined by researchers. There has been a recognition that perhaps many of the detrimental effects noted were related to the drabness of the surroundings, lack of toys to stimulate the senses, impersonal caretaking by a constantly changing staff, and impoverished experience with being talked to and played with. The research literature now includes a number of studies of babies who grow up in homes where they experience "multiple mothering," of the effects of maternal employment on children, and at least one study of the physical and mental development of infants in day-care centers. No study of short-term, intermittent separation from the mother--such as a baby experiences in day care--has thus far demonstrated the damaging consequences seen in "institution" babies.
>
> There continues, however, to be an entirely appropriate and deep concern on the part of both professionals and parents that infants should receive individualized care, not "assembly line" attention in groups. The kind of care that safeguards health, builds trust in the world and competence to cope with learning, develops language and motor skills, and encourages social interests is of tremendous importance, for the crucial nature of all experiences in the first years of life is by now clearly recognized.

Hours of Contact with Children

The hours of contact in center-based programs is greater than in those that are home-based. Twenty-two PCC's have home-centered programs or a home component and provide from one-half hour to five hours of contact per week with the children. Four PCC's provide from six to 45 hours of home day care. The home-centered programs usually consist of an educational aide (sometimes called parent educator or infant educator) visiting the home of the children to provide some kind of educational stimulation for the children on a one-to-one basis and to provide a model for the mother in working with her own children. In addition, the aide usually provides counseling or referral services for the family. The home day care programs are provided for mothers who are working or are engaged in activities at the center, and the care is provided by mothers other than those enrolled in the PCC's. A northwestern urban day-care mother is described by one of KAI's observers:

> The woman was probably about fifty years old and had one child still in grammer school--whom we did not see. She was caring for two Negro children--one about 2 1/2, whom we saw, and the other a baby brother, who was napping. The child seemed happy and relaxed, more quiet than average for his age, and had a few toys and pictures to play with. The day-care mother seemed relaxed, interested, and positive in her attitude toward the little boy. She and the worker pointed out that he has brightened considerably since she has cared for him. His mother, who is now taking a secretarial course, used to leave him and his brother in one nearly bare room for most of the day.

The variation in amount of time of contact with the children in center programs depends on the pattern of service. Some PCC's provide some time for all the focal children five days a week; some have programs for the children for one, two, or three days a week; others have morning and afternoon programs for different age groups. One associate describes a one-day-a-week program at a rural southern center:

> Presently the center is open for children four days a week from 10:00 a.m. until 2:00 in the afternoon. There is a different group of children each day and they spend their time, depending on their age, in sleeping, eating, painting, working with clay, drawing, playing with toys or blocks, lying in a crib with mobiles above their heads, or listening to records.

The number of hours per week of contact with infants and toddlers for the 27 center programs are distributed as follows:

7	PCC's provide 1/2 hour to 4 hours of children's center program
9	PCC's provide 5 hours to 10 hours of children's center program
5	PCC's provide 11 to 20 hours of children's center program
6	PCC's provide 21 to 40 hours of children's center program
27	PCC's providing center programs

Size of Groups in Children's Programs

The size of the groups in center and home day-care programs vary according to the age of the children, the size of the facility, and the personnel available. Some interesting variations of groups sizes are:

> --In a western urban center, four infants and 21 toddlers are provided separate programs for 20 hours a week while their mothers attend a work study program.
>
> --In a Rocky Mountain PCC, 24 children are provided with a home day-care program in eight homes, and 12 three- and four-year-olds attend a four-hour-per-week center program. These 36 children are also visited in their homes for 1/2 hour a week, in addition to nine children who receive home visits only.
>
> --In a southern urban project, 14 infants, 15 toddlers, and 16 runabouts are provided with a program of cognitive stimulation in separate groups for six hours a week in the center. In addition, they are visited on an individual basis in their homes for one hour a week.
>
> --In a western urban center 19 infants are brought to the center for two hours a week by their mothers to participate in a program of infant stimulation under the direction of a Program Coordinator. The toddler program has 43 children enrolled in a center-based play group and has an average daily attendance of 30 for 15 hours a week.
>
> --In a rural southern program, 39 children are cared for by 18 Alternate Home Mothers in the latter's homes for eight hours a week; 15 two- and three-year-olds and five three- and four-year-olds attend a five-hour-a-week center program; all of the children are visited in an individual home visit for three hours a week.

--In a midwestern rural PCC, 143 infants and toddlers attend five centers for five hours a week. Of the 143 children, 74 receive individual home visits.

Staff Patterns

Twelve PCC's have 24 teachers; 23 have 115 aides and nine have both teachers and teacher aides. Eleven projects have neither teachers nor teacher aides; however, eight have employed one of the ten Child Development Specialists hired by the PCC's. Eleven centers have hired 29 Parent Educators and four have selected 42 day-care mothers. Teachers and Child Development Specialists are considered to be professionals and, with the exception of one center, are not involved in any systematic training program. Teacher aides and Parent Educators (or any number of other names applied to home visitors) are nonprofessionals, who are indigenous to the community and in some cases are parents of PCC children. The home day-care mothers are usually neighborhood people, except in the case of one PCC, where the "alternate home mothers" are lower middle-class women trained in methods of day care. A variety of training programs are provided for the nonprofessionals by in-house professional staff, consultants, University Affiliates, community colleges or universities, or combinations of these resources.

The ratios of professional to nonprofessional staff of the children's component are as follows:

All professional or more than 1:1	= 3 PCC's
1:1 to 1:4	= 12 PCC's
1:5 to 1:10	= 14 PCC's
All nonprofessionals	= 4 PCC's
	33 PCC's

The difficulties of recruitment of professionals trained in the field of toddler and infant education and their inability to supervise programs are not reflected adequately in the above ratios. KAI observers repeatedly commented on the lack of knowledge and understanding of this age group by the PCC staffs. Warm attitudes toward the children were displayed, but a typical observation was expressed by a FRA in a large northern urban program.

> One Child Care Worker has primary responsibility for the infants served at the Center. In this capacity she feeds them while holding and talking to them, changes them, and generally meets their physical needs. They are stimulated while awake but not necessarily in such manner to progressively promote cognitive development. Conversations with these workers reveal they were acting intuitively and not in relation to training received at PCC.

PCC's developed some innovative staffing patterns in order to meet the needs of the communities in which they worked:

> --Three PCC's trained neighborhood women to become "Infant Educators." Following the Gordon model of infant stimulation, the Infant Educators visit the homes of PCC families and demonstrate a sequential series of infant exercises in order to develop the cognitive and loco-motor-sensory skills of the children. The Educators act as models for the parents, while directly teaching the children.
>
> --In a southern state where group care of infants is illegal, a program was developed that not only served PCC families, but also provided useful and productive jobs for senior citizens. "Senior Friends" visit PCC children in their own homes and provide care for the children while the mothers attend center functions. The "Friends," who are over 60, received a training program that prepared them for their jobs with the children. The stability and lack of turnover of the elderly is one indication of the enthusiasm with which this program has been received.
>
> --In a rural southern community, Alternate Home Mothers provide day care for the children of PCC families. The children are exposed to a variety of experiences that are found in most middle-class homes. The concept of the Alternate Home Program implies that by providing the child with a rich environment and giving some relief to mothers, the child will benefit and be provided some of the experiences necessary for a later, healthy development. Most of the Alternate

Home Mothers who have remained after the first year are over 40 years old.

Parent Involvement

PCC parents have been involved in the children's programs in various ways:

- --as paid staff
- --as members of the PAC
- --as participants in home-centered programs that demonstrate methods and techniques of working with and teaching their children
- --as volunteers in children's center programs
- --as participants in parent education programs

Twenty-two PCC's hire parents as members of the staff. This is probably the most effective method of changing child-rearing patterns within a community. The technique of preparing the student (mother) to become the teacher (staff) is a most effective educational approach. Problems such as rivalry for the few jobs and confidentiality, have occurred as a result of these hiring practices. However, in interviews with the KAI observers, mothers have expressed their changing attitudes toward the rearing of children:

> I saw and talked with some mothers as well as staff members, since in both places the nursery activities were going on while I was present, and a few of the mothers were on hand. This visit impressed me; there was evidence that the families participating are beginning to be aware that exciting and worthwhile things are happening to the children who are attending the center. Several specific incidences of dramatic change in a child's behavior were cited to me, one of them by a mother herself. The mother had observed that her child is becoming more active, notices and plays with more things around the house, and is more verbal in both English and Spanish, even though the only language used at the center is English.

Parents and community members constitute at least 50 percent of the Policy Advisory Committee. From observations of FRA's and reports of PCC directors, the role PAC's have played in developing and implementing children's programs is unclear. We do know that some directors worked closely with PAC's toward establishing a children's program that would meet many of the needs of the infants and toddlers of their communities. When parents were involved in planning, day-care programs were most often chosen.

The approaches used in the home-visiting programs vary in terms of location, personnel, and the philosophy of the PCC. Those PCC's that focus on the parents use the home visit as a time for discussing family problems and counseling while three PCC's follow the Gordon model. Other programs have developed a "bank" of toys, equipment, books, and materials for young children that are brought by the home visitor to the children in order to demonstrate to the mothers how these materials can be used to stimulate intellectual and psycho-motor development. Our FRA describes such a program located in a southern urban community:

> It was a five-minute walk to the home of ____ who has sons aged three and two, and twin daughters who are five months old. There were two assistant teachers in the home when we arrived. During the approximately 45 minutes the teacher and I observed there was considerable activity by the teachers in talking to the children, reading and looking at books, playing with a ball, and building block towers. The infants were held and talked to, they played with toy animals, and looked into a mirror. The atmosphere was both natural and friendly. The aides seemed to have established good rapport and the mother discussed infant feeding, sleeping, and toilet training quite freely, as well as relating anecdotes of her sons' behavior of recent days.
>
> There was very little verbalizing from the two boys, a pattern that, according to the training coordinator, is rather common among children of the center. She stressed that improvement in this ability is one of their major efforts.

KAI's observers have indicated that this part of the program is well received by the parents.

The PCC's vary in the amount of parental involvement they require in the children's programs. One program with a strong PAC, requires that parents participate in the center and drops those families who do not; another PCC that has strong staff direction, prefers to have parents divorced from the children's program, because it is easier to run a schedule without the "interference" of the parents. Three PCC's pay mothers a nominal fee to participate in a part of the children's program, while others require the mothers to "volunteer" some time. One southern urban program illustrates this point in a KAI observation:

> An official requirement is that each mother or mother substitute must participate in the first hour of the "training program," where they are to learn the different ways of "working with the children."
>
> Typically those mothers most active will participate with the teachers in encouraging the children to play with, or attend to, various pieces of equipment or sources of sensory stimulation. Each age group is scheduled for five to six children on any one day, but full attendance is rare. Each teacher reported that about one-third of her parents (mothers) could be considered very actively involved. After the first hour's participation, the mothers are invited to participate in various programs regarding nutrition, health, sewing, and other domestic skills.

Sixteen PCC's terminate families when the mother gets a job, while one other PCC provides day care, but insists that the mothers participate.

Relationships of Center Staff and Structure to Type of Children's Programs

It would seem reasonable that there should be relationships between the decision-making structure of a center, the staffing pattern it evolved, and the kind of children's program that it developed. While the number of centers is too small for a statistical test of relationships between these component models, it was possible to discern some relationships by "collapsing" the models into cruder categories and plotting the centers accordingly. Table 16 requires some prior definition, therefore, before the reader can interpret it.

1. For the purposes of this table, programs for children were dichotomized as "structured" or "unstructured." Three programs that do not serve children at all are not included in this table.

2. The source of control of the PCC is trichotomized rather than using the finer model of level of parental participation.

3. The staffing models used are described in the chapter entitled "The Parent-Child Center Staff."

It is evident that this breakdown is not useful in differentiating or clustering programs. As was discussed in the section on staff, the variables found most relevant to program type were the program's location (urban or rural), the professional training of its director, and whether or not the program was parent directed.

TABLE 16

Coincidence of Staffing Pattern, Source of Program Direction, and Type of Children's Program

Staffing Model	Sources of Direction						
	Staff		Parents		Outside Agency		
Childrens Program:	Structured	Unstructured	Structured	Unstructured	Structured	Unstructured	N
1	0	3	0	0	0	1	4
2	2	3	0	3	0	1	9
3	0	2	1	3	0	1	7
4	1	0	0	0	0	0	1
5	2	6	3	1	0	0	12
N	5	14	4	7	0	3	33*

* One center not yet funded, two centers have no children enrolled (one staff directed and one outside directed).

THEORETICAL BACKGROUND FOR PROGRAMS

It is beyond the scope of this report to review the current range of theories of child development, but some brief description is necessary if the programs of the Parent-Child Centers are to be seen in perspective. For the purpose of this description, we suggest that most of our dominant theories can be crudely sorted into three main categories.[1]

Developmental-Affective Theory

One way to look at a child's behavioral development is to assume that his capacity to learn and adapt emerges in a regular, naturally determined sequence. Like the blooming of a flower from a bud, each step in development is predetermined and will occur if the environment provides the raw materials and stimuli required by the individual's developmental blueprint. The operational implications of this point of view, which we will label "developmental theory," are clear. From this viewpoint a program for children should be relatively unstructured and should provide as wide a variety of opportunities for exploration and as wide a variety of materials as possible. Since each child is unique, any structuring of the program will impair his individual development; since each set of needs is different, the materials to meet all possible developmental needs should be present. Since each child's pace and readiness is determined by an internal developmental clock, any attempt to schedule group accomplishments will serve as a Procrustean bed for most children. The net result of these considerations produces a permissive, unstructured setting with an enormous variety of materials and stimuli and encouragement of individual activities at individual rates.

---

[1] Like all category systems, this one will do damage to some theories, and will lump together some whose differences, while subtle, are real.

In practice, programs based on these theories have also incorporated another theoretical notion derived from psychoanalysis. This idea maintains that intellectual accomplishment derives from emotional development; that until the major tasks of emotional development have been accomplished, the child is unable to turn his emotional energies to such nonemotional tasks as reasoning, reading, symbol use, and abstraction. Given good emotional development, intellectual ability will, according to this idea, emerge "naturally" when the child is developmentally ready for such "nonconflicted spheres of ego-development."[1]

Operationally, the inclusion of this theory means that there is considerable stress placed upon affection, the free expression of feelings, and encouragement of emotional display, and little stress, in the preschool years, on the deliberate teaching of reading or arithmetic or other "academic" skills.

In the remainder of this report, we shall refer to these theories as "developmental-affective" theories and to programs based upon them as "unstructured." Among contemporary theorists whose work we classify in this category is Lois Barclay Murphy, and among practitioners, the day-care center directed by Mary Elizabeth Keister, whose program is described later in this report. It should be pointed out, however, that none of the PCC's whose programs are derivative of these theories so describes itself--and none of them has identified or deliberately derived its programs from an explicit theoretical framework.

Cognitive Stimulation Theory

A second major set of viewpoints in contemporary work with children stresses the importance of specific opportunities to learn specific skills. Recognizing the concepts of developmental readiness, these theorists and practitioners reject the notion that, given a wide menu of activities from which to choose, the child will accurately assemble a balanced behavioral "meal" for himself. Instead, they point to studies which demonstrate that children can learn complex skills at much earlier ages than was believed possible, when such skills are specifically taught. They further believe that, since each culture does in fact have certain basic skill requirements for individual survival and success, it is more helpful to identify and teach these than to wait for them to emerge through what may be accidental imitation. In work with the deprived child, they see such deliberate prescription of learning as essential to fill in the gaps in his environment's "curriculum." They point out that there is a hidden curriculum for the middle-class child, and that failure to be exposed to this curriculum is a sometimes insurmountable handicap to the lower-class child.

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[1] Phrase from a private communication with David Rapaport, August, 1946.

Operationally, programs which derive from these considerations do not usually deny the importance of positive affective experiences: they see them as essential learning experiences. They do differ from the developmental-affective programs in significant ways. Their programs are structured; a specific set of activities and materials, presented in a specific sequence are part of--or are--the programs. Explicit learning goals are set and movement toward those goals are rewarded. These programs do differ in the extent to which they are actually explicit--Ira Gordon's Infant Educators administer a set of "cognitive stimulation" exercises derived from Piaget; the Infant School of the Fifth City teaches lessons of extraordinary specificity in both content and behavioral goals. Because all of these programs are concerned with cognitive and perceptual development (though not exclusively) we will label them "cognitive stimulation" theories, and describe them as "structured." Among the programs and research we are classifying in this category are those of Ira Gordon, Bettye Caldwell, and Frank Palmer. These programs will be described later in this report.

Unlike the "developmental-affective" programs, PCC's that have derived their programs from the "cognitive stimulation" models are usually explicitly aware of this derivation and in some cases have had their personnel trained by the authors or staffs of their program's model.

Social Service-Parent Education Theory

A third way to look at enhancing the child's development derives from psychoanalytic theory through social casework practice. The basic argument--grossly simplified for this brief discussion--was most parsimoniously stated by Eric Erikson:[1] "Neurosis in a child is always a symptom of crisis in the significant adult in his life."

Since the very young child is intensely dependent upon his parents for affective and cognitive stimulation, for nurture and care, for support and defense, and is a victim of their child-rearing practices, it is argued that the most effective service to the infant and toddler is support and/or education of his parents--particularly his mother. If the mother becomes a "good" parent, then she will do the things necessary to raise her child well, so there is no need to do very much directly with the child if an adequate program of service is developed for the parent (mother).

This point of view breaks down into two operational paths, depending upon the professional identification of the program operator, and consequently, his view of the parent.

One of these paths we shall label "counseling and social services." In the counseling and social service model, the child's development is primarily affected by the mother's emotional condition. To improve her mothering ability she must receive such counseling or psychotherapy as will optimize her mental health. A "healthy" mother will then provide an optimal emotional climate for the child (note the theoretical overlap with the developmental-affective approach discussed above). In a program based upon this approach we find little or no direct service to children and a heavy staff concentration on social casework. The mother is seen as a "client" (or patient) who is to be "treated." In this role she cannot also be a member of the staff. From this point of view, every family casework agency adequately serves the infants and toddlers of their clients.

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[1] Eric Erickson, Childhood and Society (New York: W.W. Norton, Inc., 1950).

As we will see, several PCC's are built on this model, and one, which has a large professional staff, has only caseworkers and one recreation specialist among its professional staff, provides no services to children directly, and provides only a "baby-sitting" room for a few parents who bring their children to the center from time to time.

Another operational path from this viewpoint we can label "parent education." The importance of the parent is again paramount, but successful child rearing is seen, not as a by-product of a healthy personality, but rather as a product of specific knowledge and skills as a parent. (Note the overlap with the cognitive-stimulation theories.) In a program based upon this view, the parents are taught specific homemaking and child care skills, and are taught about child development as a body of knowledge. Given such skill and information she should then be a "good" mother. As in the other path, direct service to children is secondary, and where provided is seen either as a service to the mother to allow her to attend classes or as a means of demonstrating "good" practices.

Only one Parent-Child Center has chosen this as its primary operational path; however, every Parent-Child Center includes some type of parent education. Usually, such programs are unstructured, vis-a-vis the child, but highly structured vis-a-vis the parent.

Parent-Child Centers--as a group or individually--are not "pure" examples of any of these theoretical categories. Each can be classified in terms of its predominant thrust, but all are eclectic to a certain extent. Their thrust as well as their catholicity seems most related to the training of their director--social service directors have the least eclectic programs; directors with the least relevant training, the most eclectic, as shall be discussed later.

Classification of Programs by Type of Intervention Environment

Programs vary along other important dimensions as well, and we have made an effort to select those few that seem most relevant to the description of programs for very young children. At a recent meeting of scientists engaged in research in infant programs, it was agreed that a schema developed by Dr. Bettye Caldwell contained the four variables most crucial to the description of a program designed to intervene in the development of an infant. These included (1) the degree of structure (or focus) of the program, (2) the level (amount) of affect of the staff working with the children, and (3) and (4) the amount of and type of direct contact between adults and children. By (crudely) dichotomizing each of these variables, 16 broad program types are defined. We classified each of the PCC's into these types, and the numbers of PCC's falling into each of these categories is indicated on Figure 3.

Several aspects of this distribution are noteworthy.[1]

--Only nine, or 24 percent, of the programs provided more than 15 hours a week of direct contact with the child.

--Twenty-six, or 68 percent of the programs provide the contact in groups.

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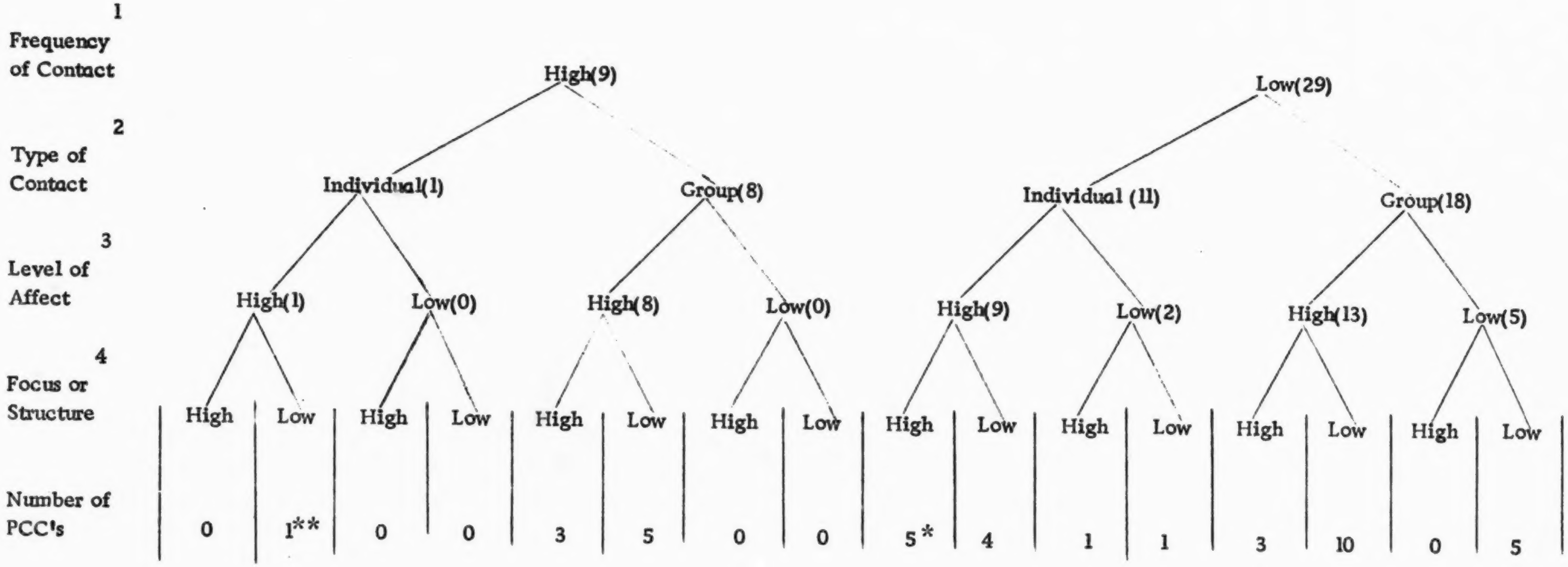
[1] Those centers which had separate home- and center-based programs for different groups of children were counted twice. Thus, in this classification there are 38 programs, but only 33 centers.

FIGURE 3

Schema for Describing Infant Intervention Programs


Frequency of Contact[1]
Type of Contact[2]
Level of Affect[3]
Focus or Structure[4]
Number of PCC's
High(9)
Low(29)
Individual(1)
Group(8)
Individual (11)
Group(18)
High(1)
Low(0)
High(8)
Low(0)
High(9)
Low(2)
High(13)
Low(5)
High
Low
0
1**
0
0
3
5
0
0
5*
4
1
1
3
10
0
5

NOTE: 33 centers have 38 programs, because 5 centers have home-based programs for some children and center-based programs for other children.

[1] Frequency refers to amount of contact child has with enrichment environment. High frequency would be defined as 15 hours per week or more.

[2] Type of contact is self-explanatory, referring as it does to whether the intervention is offered via individual instruction or tutoring or a therapeutic one-to-one environment or whether it is offered to the child as a member of a group.

[3] Affect refers to the intensity of the emotional climate in which intervention is offered; specifically, high affect refers to an environment in which a warm and loving relationship between teacher and pupil is stressed.

[4] Focus or structure refers to the extent to which the intervention environment is planned and learning activities guided by the program plan.

* All home-visiting programs

** Day-Care homes

--Thirty-one, or 82 percent, have a high level of affect.

--Twelve, or 32 percent, have structured or focused programs.

Thus, the most prevalent program provides a low frequency of group contact in an unstructured, affectionate curriculum, and ten of the programs (26 percent) fall into that type. If we eliminate the affect variable, the number rises to 15, or 39 percent.

Among the nine programs with high frequency of contact, eight are high-affect group programs.

Among the 29 programs with low contact frequency, 18 are group programs, 22 are high-affect programs, and 20 are unstructured.

Thus, overall, six of the possible 15 program types generated by this set of variables are not represented at all, and three are represented by only one center each. While there is considerable diversity among programs along other dimensions, the range and distribution in regard to these crucial aspects of the children's programs are both limited and uneven. Because only limited instruction as to program alternatives was given to the Policy Advisory Committees and their predecessor Planning Advisory Committees who were responsible for program design and employment of the director, we interpret this distribution, in part, as representing the relative extent to which these alternatives or their implications are generally known in the population at large.

The variations and range of PCC programs that have developed are often directly connected with the educational resources of the area in which they are located, the kind of staff they are able to recruit, the ethnic background of the families they serve, the kind of physical facility available, and the educational background of the director. They range from a very carefully developed, professionally run nursery and infant-care program to a day-care schedule for children under three staffed by nonprofessionals; they range from totally center-based programs to totally home-visiting programs or they may be a combination center-home-visiting program; they range from an experimental university-based program to a project for Indian families and their children on a reservation; they range from serving all Black single parent families living in an urban slum to intact Appalachian families.

We will examine these programs in terms of the general "types" described above, reminding the reader again that none of these are "pure" types, they have been classified in terms of their predominant activities.

DEVELOPMENTAL-AFFECTIVE PROGRAMS

Two-thirds of the centers, with a total enrollment of 1,698 children, have chosen this type of program. Of these, eleven are rural centers and fourteen are in urban neighborhoods.

Some Non-PCC Examples

This program type is well illustrated by the Greensboro Demonstration Nursery Center and Earl Schaefer's home tutoring program. In order to demonstrate an optimum environment for children under three in daytime group care, 30 children (two months to three years old) of varied socioeconomic background living in Greensboro participated in a program designed by Mary Elizabeth Kiester.[1]

With a staff composed of three professionals and seven nonprofessionals, a child-centered, day-care nursery school program was developed providing 50 hours per week of group care with an emphasis on affective, personal, and individual attention for each child. The children are divided into five groups according to age, and are assigned the continuous and reliable services of carefully trained and chosen "caregivers." A "sick bay" is provided for children who are ill. After two years of operation, Dr. Kiester reported no real differences between the experimental group and a carefully matched control group.

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[1] Mary Elizabeth Kiester, "A Good Life for Infants and Toddlers," mimeographed (University of North Carolina at Greensboro, 1969).

A home-centered developmental-affective program was designed by Earl Schaefer, for 31 Negro males under two years of age in order "to develop positive relationships with the child and his family, and to provide verbal stimulation and varied and increasingly complex experiences."[1] The disadvantaged families in this project agreed to participate in the home-visit schedules and their homes had to be suitable for tutoring. Trained graduate students alternated weekly in visiting each child five hours per week and through age-appropriate activities (walks and trips, reading books to the children, singing songs with them, playing with blocks, toys, paints, and crafts), encouraged verbal response. The experimental children showed significant IQ gains after 21 months of involvement in the home-tutoring project, but scores dropped one year after the program was terminated.

PCC Examples

An examination of some of the programs as observed by the KAI field research associates will illustrate some of the wide variations and the range of the developmental-affective derivatives.

Center-Based Programs

An Alaska PCC provides 45 hours of day care per week in the center for children under three, staffed by nonprofessionals. The center is located in what used to be the only bar in the now dry town of Kotzebue, where there has never been any provision for the care or education of young children in the past. Training for the staff was provided in Sitka in conjunction with other Alaska Head Start programs. The FRA writes:

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[1] Earl S. Schaefer, "A Home Tutoring Program," Children vol. 16, no. 2 (March-April, 1969), pp. 59-61.

> There is no doubt that this is a good program for the children. It is a rich environment--emotionally, cognitively, physically. It is a child-centered environment--inside, outside, everywhere. It is a child-oriented staff--but then, that is the Eskimo way! There is little doubt that it is a good program for Kotzebue. It has bridged some of the divisions, it has provided activities for young adults and old folks, it has transformed a bar into a showplace.

Home and Center Programs

In a large ghetto a careful, professionally planned center and home-visiting schedule has been implemented for 55 families living in a redevelopment area of the city. Community aides visit the homes every two weeks to discuss family problems and methods of child rearing. In addition, the 60 focal children from six months to four years of age attend the center for an average of five hours a week, which includes lunch for the focal children, their mothers, and school-aged siblings. The field observer at this site describes a typical day at this center where mothers receive $8.00 for participating in the children's program four hours per week.

9:00 a.m. - 10:00 a.m.	NURSERY GROUP: Six mothers and six children (two- and three-year-olds) INFANT-TODDLER GROUP: Six mothers and six children (six months to two years)
9:15 a.m.	Small breakfast snack
10:00 a.m. - 11:00 a.m.	Family Life Education or Child Development Education for the 12 mothers. (Children remain with teachers.)
11:00 a.m. - 11:30 a.m.	MOTHER'S INTEREST GROUP: Sewing, washing, talking, shopping, etc. (Children remain with teachers.)
11:30 a.m. - 12:15 p.m.	Continued interest group or makeup time and preparation for lunch.

12:00 p.m. - 12:15 p.m.	Bus picks up Head Start and elementary school children of both morning and afternoon mothers and brings them to the center.
12:15 p.m. - 12:35 p.m.	First lunch for morning groups of mothers and children.
	Afternoon mothers arrive at center and help prepare for second lunch. (Afternoon children are occupied.)
12:35 p.m. - 12:55 p.m.	Second lunch for afternoon groups of mothers and children.
	Bus takes Head Start and elementary school children of morning mothers back to school.
	Morning mothers help clean up after lunch. (Morning children are occupied.)
1:00 p.m.	Morning mothers and children leave for home.
1:00 p.m. - 2:00 p.m.[1]	Family Life Education or Child Development Education for the 12 afternoon mothers. (Children are with teachers, taking afternoon nap.)
2:00 p.m. - 2:30 p.m.	MOTHER'S INTEREST GROUP: Sewing, washing, talking, shopping, etc. (Children are with teachers.)
2:30 p.m. - 3:30 p.m.	NURSERY GROUP: Six mothers and six children (two- and three-year-olds).
	INFANT-TODDLER GROUP: Six mothers and six children (six months to two years).
3:15 p.m.	Small afternoon snack.
3:30 p.m.	Afternoon mothers and their children leave for home.
4:00 p.m. - 5:30 p.m.	Recreation activity for elementary school children.
7:00 p.m.	Teen-age recreation group or family night at center, or adult recreation at center.

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[1] Please note the rearrangement of the afternoon program. This change was made to allow adequate nap time for children after lunch.

The difficulty of introducing any type of government-sponsored program to a southern rural population that is suspicious and fearful of strangers and of anything new is reported by a field research associate. "It was not unusual for the children to hide under the bed or for the mother to fail to answer the door either out of shyness or fear that it was a welfare worker wanting to take her children away from her." The staff of this PCC provided a program that would gently convince mothers to participate in the center with their children. In contrast, a busy southern urban program is described by another associate:

> The child-care and parent-education programs being conducted at the center seem to be off to an excellent start. Each program has its own space, and two teachers are assigned to each program full time. The nursery also has the services of an assistant teacher, two parents-in-training, and the curriculum coordinator. The parents spend a week at a time in the nursery. When the center first opened, it operated a single all-day program for 18 parents and 23 children from nine to two in the afternoon. Now it handles 33 parents and 42 children, operating two half-day programs, one from 8:30 to 12:00, and the other from 12:30 to 3:30....
>
> It appears that the nursery program is more or less a traditional day-care operation, with demonstrations by the research and evaluation coordinator and the curriculum coordinator being used to move teachers and parents gradually to adopt the stimulation techniques developed by Florida's Gordon Project.

The flexibility and adaptability of developmental-affective programs have had advantages for some of the rural PCC's. One western project found that during the summer, the mothers had to work in the fields to harvest the crops, and the PCC provided longer day-care hours for the children in order to accommodate the need. In another Rocky Mountain PCC, the parents and staff found that programs they had originally planned were impractical because of long distances between the homes and the center. After several revisions, a program of home-visiting was instituted and the KAI observer says:

> The mothers seem to welcome the visits by the Parent Educator and her aide, and to accept suggestions eagerly. The toddlers enjoy the sessions too, apparently, and seem happy to play with the new toys from the Toy Bank while the Parent Educator talks with the mother about the child.

Home-Based Programs

There are four developmental-affective, home-visiting--only PCC projects, which combine infant education with counseling and other social services. The home visitors, who are nonprofessionals with varied kinds of preparatory training, visit the homes anywhere from a half hour to eight hours a week per child. One of the four programs provides 40 hours per week of group home care for the focal children, in addition to the home visiting. Observations of home visits by our field staff have been limited since many centers are reluctant to risk an observer upsetting the often tenuous rapport established between a family and the home visitor. Generally, the home visitors try to provide some kind of "enriching" experiences for children similar to those described in the Schaefer program, such as playing with blocks or puzzles they've brought with them or singing and reading to the children. In one urban center, lower-middle-class mothers are trained by university staff to equip them to become "home day-care mothers." A field research associate reports an interview with an attractive "day-care mother" who lives in a housing project with her husband:

> Mr. __________ has some contact with two of the children before he leaves for work and when he comes home at night, giving them an experience, even though limited, with an adult male, which is generally lacking in their lives.

> The child development aide visits the day-care home three times a week. She brings equipment, program ideas, and conducts some programs with the children herself. She has conferences with the day-care mother and each of the natural mothers, during which time she talks with them about nutrition, child-rearing problems, and whatever else seems indicated at the time. She makes referrals to the nurse if she feels a health problem exists.
>
> Mrs. __________ has one child of her own in the program and takes in four others. She is temporarily taking care of another child while the mother is working during the pre-Christmas rush. Her own child in the program is five years old and goes to school afternoons. Mrs. __________ receives $18.75 per child for a five-day week; this includes $3.75 per child per week for food--two snacks a day and lunch.

In another home-based unstructured rural program in a state that prohibits group care of infants and toddlers, women over 60 (Family Friends) provide a program in the homes of the children while the mothers attend the center. The Family Friends visit the homes for an average of three hours a week and bring toys that they have made, in addition to serving as "advisers and counselors for the mothers." The FRA observes, "Visitation appears to have a friendly flavor and relationship. In the homes the mothers are taught to care for the child's health, to feed it and the family, and how to effect a better relationship among members."

Facilities and Equipment

The philosophical approach of some PCC programs for children is influenced by the physical facilities they occupy and the equipment they purchase. A field observer points out that in a rural western PCC, "whatever plans the supervisor originally had to base the program upon theory, the practical requirements of a rapidly changing center environment have so far forced her theoretical orientations into the background." Another rural PCC operates with a poorly functioning stove, and mothers are reluctant to bring the children to the center when it is cold. Two urban PCC's have been unable to begin operation and four others have been restricted in operation and function because of difficulties in finding adequate housing and then meeting the requirements of strict codes established for children's centers. Our observers have also noted that much of the equipment purchased by or donated to the PCC's has been more appropriate for older Head Start children than for infants and toddlers. In a recent examination of a catalog of a large children's equipment and toy manufacturer it was found that the greatest emphasis was on the sensory-cognitive designed toys and equipment for three- and four-year-olds and that there were relatively few items for toddlers and infants. In order to provide appropriate equipment and materials for the infants, toddlers, and runabouts, there would have to be a fairly sophisticated staff that was knowledgeable and aware of the needs of this age group.[1] The problem of finding this kind of staff is described by a KAI observer in an urban area:

> Both teachers are young and enthusiastic about poverty child care and development. They are remarkably untrained in the age group for which they are responsible. The senior teacher underestimated the age of her toddlers to me more than a year on three different occasions; had she had any awareness of developmental levels in the years one through three she would not have erred to this degree. On the other hand, this teacher is devoted to her work. She does more cognitive stimulation and language training than I saw at other centers. Even her work falls short of what could be done if she had sophisticated consultation and training.

Staff Training and Supervision

In the developmental-affective type of program there is an uneven quality of the staff, and their training and supervision.

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[1] Our own experience indicates that a local variety store is a more appropriate source of play materials for infants than are toy catalogs.

The Greensboro and Schaefer projects described above provided an extensive pre- and in-service training component for the total staff--professional and nonprofessional--as well as close and careful supervision. In a philosophy that emphasizes "taking the child from where he is," one that recognizes the intuitive quality of teaching, one that gives weight to a warm and loving environment as being a key to a "good" experience for children, it is possible to oversimplify the program and neglect some essential pieces of knowledge and skills necessary to produce a model such as Mary Elizabeth Kiester's. So, while baby-sitting may provide a warm, affective environment, it is no substitute for an individually tailored program for the child that provides age-appropriate equipment, toys, and experiences, in small groups with the same "caregiver." The seemingly common-sense assumptions of the developmental-affective philosophy, stated by Evangeline Burgess, indicate the high degree of sophistication necessary in order to implement a program for young children: "First, young children's interests can be utilized to facilitate learning....Second, learning which comes through many sensory channels is likely to be more permanent and more readily accessible for future use in different situations....Third, among young children in a group, the readiness--either by reason, mental ability, maturation, or experience differs greatly. Fourth, curiosity, exploration, manipulation, and experimentation all feed cognitive processes....Fifth, incidental or latent learning often furnishes experiences which a child uses for future problem solving. Sixth, not enough is known about how to facilitate specific learnings to justify any one approach to a learning task. Seventh, children learn from interaction with each other....[1]

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[1] Evangeline Burgess, Values in Early Childhood Education (Washington, D. C.: National Education Association, 1965), p. 46.

The theory that all one has to do to staff a program for infants and young children is to provide a warm, mothering environment has been disputed by some who work with the disadvantaged child:

> The most important aspect of the stimulating interpersonal environment is the behavior of the interpersonal environmental agent who interacts with the child and mediates between the child and the physical environment. The following outlines the minimum behavioral requirements for an effective environmental agent: (1) An effective environmental agent provides a rich verbal climate, describing events and their relationships and encouraging a high level of verbal productivity and interaction; (2) the effective agent provides direct mediation between the physical environment and the child by (a) ordering the physical and spatial environment by monitoring and directing attention to the relevant dimensions of the stimulus-informational input; (b) ordering the temporal environment by monitoring and directing attention to the sequence of environmental events; (c) ordering tasks sequentially in magnitudes of just manageable difficulty to insure successful accomplishment; and (d) providing an appropriate response model which the child can emulate and imitate in a variety of environmental contexts. (3) The effective environmental agent provides motivational support by (a) creating a reality-oriented emotional attachment which matures from dependency to active, involved encouragement of independence; and (b) using a range of reinforcing techniques which are appropriate to the task. Reinforcement should move from the concrete to the abstract and from the extrinsic to the intrinsic.
>
> These appear to be a set of minimum behaviors to provide a stimulating, interpersonal environment. Such a model may move as somewhat beyond the description of "warm, affectionate adults" and lead to productive hypotheses and development.[1]

KAI observers have pointed to the difficulties of recruiting, maintaining, training, and supervising the children's program staff under trying circumstances. The experimental projects we have described, have focused narrowly on the children in their programs and have not had to deal with the many problems of CAA's, delegate agencies, families, facilities, funding proposals to be written, advisory committees, and the many other situations inherent in developing and implementing PCC programs. There is an underlying thread that runs through the FRA's observations, and that is that the potential of the professional and nonprofessional staff is great, but it has not been fully developed. Peanuts says in the Shultz cartoon, "There's no heavier burden than a great potential," and the question remains as to how to lighten the burden.

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[1] James Miller, Review of Selected Intervention Research With Young Children (Urbana, Illinois: National Laboratory on Early Childhood Education), pp. 16-17.

Typical observations of FRA's describe the untrained staff and their needs:

> _________ has a real capacity for developing rapport with children but she lacks the simple skills one picks up under effective supervised training; e.g., she moves in on children too rapidly and tends to tower over them. In general, the staff seemed oriented to cognitively aimless activity with children. Contacts were of the type one finds made by nonspecialists who, more or less, enjoy children and engage with them in social chatter, mild teasing, and some affection.
>
> The home-visiting staff, now that they have a beginning caseload, appear to be fairly active. As mentioned, they have started their round of home visitations. Thus far, they have no specific program to follow in making these visits, other than to look for generalized ways of helping and to inform the families about PCC schedules and programs. There is indication that a rather strong paternalistic orientation exists in the home worker staff despite their so-called status as resident types.

The lack of role definition between professional and nonprofessional staff is another problem that often occurs in a loosely structured program. One urban PCC of the developmental-affective type apparently has successfully worked through this situation by working side by side, rather than the professional being "desk-bound."

Outside consultants, in-house professional staff, University Affiliates, and Program Advisers assisted in the training and education of the staff of the children's programs. These programs were predicated on the notion that intensive, well-planned short courses, institutes, and/or seminars could provide the support and education necessary to provide the staff with the tools necessary for the kind of programming the children required. As the PCC's have developed, the cummulative effects of the input of the trainers and educators did improve the quality of some of the children's programs, but the need for more effective training remains.

COGNITIVE STIMULATION PROGRAMS

Briefly described are five experimental programs that deal with infant and early childhood intervention with disadvantaged children that fall into the category of cognitive stimulation. These are then compared with some of the PCC projects in that category.

Some Non-PCC Examples

The Nonprofessional as Infant Educator[1]

Ira Gordon developed a program utilizing the services of women from disadvantaged neighborhoods as teachers of poor mothers in techniques of infant stimulation. One hundred seventy-five mothers and infants participated in their homes in a program conducted by 15 full-time and six part-time parent educators. Each child was seen one hour a week. A program of pre- and in-service training dealing with infant stimulation tasks, interview techniques, observation procedures, and record keeping was conducted for the parent educators. The experimental children scored significantly higher on IQ tests after one year of the program; in addition, the mothers showed an increased self-esteem, a sense of interpersonal adequacy, and a great regard for their own personal appearance.

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[1] Ira J. Gordon, "Stimulation Via Parent Education," Children vol. 16, no. 2 (March-April 1969), pp. 57-59, and Ira J. Gordon, "The Young Child: A New Look," in Early Childhood Education Rediscovered, ed. Joe L. Frost (New York: Holt, Rinehart, and Winston, Inc., 1968), pp. 11-20.

Ypsilanti Infant Education Project[1]

That preventive programming for disadvantaged children must begin before preschool is a basic assumption of David Weikart. In a project involving public school teachers visiting disadvantaged infants and their mothers once a week for an hour, individual programs are developed to encourage language, motor, and cognitive skills. The teachers have been trained in a systematic, sequential approach based on the Uzgiris-Hunt Scales. Significant gains were achieved by the experimental group after the intervention.

Concept versus Discovery Training Project[2]

Two hundred forty, Negro, two- and three-year-old males of lower socioeconomic backgrounds attended the Harlem Research Center in New York for two one-hour sessions each week for eight months in an experimental program designed to determine the effect of different kinds of intellectual stimulation. Half of the children received "concept" training, i.e., basic concepts such as "top of," "wet," "smooth," "far," "many," and "different," were presented and verbally labeled. The remaining group received "discovery" training, i.e., the same materials were provided the children but the instructors did not label the concepts for them.

Francis Palmer found that the children from both "concept" and "discovery" groups performed better than the comparison groups on 14 of 16 measure (9 were statistically significant). The gains held for a year in most of the assessment measures. The "concept" group performed better on four measures than the "discovery" group. Both groups did as well or better on all other measures than the middle-class children in the control group. Possible reasons for the superior performances were:

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[1] David Weikart, Ypsilanti - Carnegie Infant Education Project, Progress Report (Ypsilanti, Mich.: Ypsilanti Public Schools, Department of Research and Development, September 1969), and David Weikart and Dolores Lambie, "Preschool Intervention Through a Home Teaching Program" in The Disadvantaged Child, Volume 2, ed. Jerome Hellmuth (New York: Brunner/Mazel Publishers, 1968), pp. 435-500.

[2] Francis H. Palmer, "Learning at Two," Children vol. 16, no. 2 (March-April 1969), pp. 55-57.

1. Regular exposure to a structured learning condition,
2. Effective relationship of child and instructor,
3. Continuous relationship of child and instructor, and
4. The children's increasing awareness of rewards for responses to stimulation.

Children's Center[1]

Bettye Caldwell and Julius Richmond established a Children's Center in Syracuse in order to provide an optimal environment for children from six months to three years of age for 12 hours per day, five days a week. The project goals are to provide a group day-care program for children of low-income families, to develop their sensory and perceptual discrimination, their feelings of mastery, a favorable self-concept, and their cognitive abilities. Individual attention from adult staff members with the infants is arranged for at least one-half hour in the morning and afternoon. Sleeping and eating schedules are individualized and the same caretaker (the adult/child ratio is 1:4) provides an environment with an emphasis on verbalization through age-appropriate learning games. The older groups receive individualized attention in an atmosphere that encourages verbalization and concept formation. Sensory materials, story-telling and music, plus many other experiences that develop cognition, language, and self-concept are presented to the children. Parents are encouraged to participate in meetings and conferences at the center.

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[1] Bettye M. Caldwell and Julius B. Richmond, "Programmed Day Care for the Very Young Child--A Preliminary Report," Child Welfare vol. 44, no. 3 (March 1965), pp. 134-142, and Bettye M. Caldwell, "What is the Optimal Learning Environment for the Young Child?" American Journal of Orthopsychiatry vol. 37, no. 1 (January 1967), pp. 8-21.

Academic Preschool[1]

In order to induce learning at an above average rate with preschool disadvantaged children, Bereiter and Engelman devised 15 behavioral objectives they considered essential for later school success. The children in the experimental groups received direct instruction, practice, and correction in order to achieve the goals. The classes were conducted two hours a day, five days a week in a structured, staff-directed schedule that included pattern drills in language, arithmetic, and reading. Positive reinforcement was used as well as firm disciplinary procedures in achievement of goals. The experimental groups achieved significantly greater scores than the comparison group after two years of intervention. While the children involved in this program are older than the focal PCC children, the Bereiter-Engelman philosophy is one that has been adapted, in part, by educators concerned with infancy.

PCC Examples

Seven urban PCC's have committed their total children's program to a cognitive stimulation philosophy, while three urban and one rural have chosen to place part of their children's component into a structured mode. A total of 514 children are enrolled in programs that are similar, in part, to one or more of the experimental models discussed above. While the PCC's that have chosen to follow this route adhere to specific models, they have all adapted their programs according to the availability of trained personnel, location, ethnic requirements of the community, and the practical everyday problems of operating a PCC. Before describing the cognitive stimulation type of PCC's, there are some differences that may be observed in a comparison of the experimental and PCC programs:

1. The experimental programs are much narrower in focus than most of the PCC's. The experimental programs are primarily focused on the

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[1] Carl Bereiter and Engelman, Teaching Disadvantaged Children (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1966), and Academic Preschool Champaign, Illinois, (Washington, D. C.: Superintendent of Documents, 1969).

child and his performance, and only one provides social services for the families (Caldwell). The Gordon program, as do most of the PCC's, concerns itself with the parent and the indigenous infant educator as well as the child.

2. All of the experimental models were designed and/or administered by professionals whose knowledge and interests are in the field of early childhood education. This is not so for PCC's. Five of the directors of cognitive stimulation type programs have educational degrees (not necessarily in early childhood); two others have degrees in social welfare, three have degrees in the social sciences, and one has no degree.

3. In only one experimental program (Gordon) are indigenous community aides the instructors. Career development is an integral part of the PCC's programs and neighborhood aides are used in all but one of the cognitive stimulation PCC programs.

4. Training and ongoing supervision for the teachers in all experimental programs is provided by professional staffs committed to the philosophical approach of the experimental design. PCC's, for various reasons discussed elsewhere, have been unable to provide this kind of training and supervision.

5. The number of children served in the experimental programs is usually smaller than those served in PCC programs of this type (the exceptions are the Palmer and Gordon projects).

Center-Based Programs

Two of the cognitive stimulation type PCC programs are center-based. One is located in a northern housing project and has been severely limited by the problem of finding adequate space in order to carry on its children's program. The teachers, who have been trained by a staff under the direction of Francis Palmer at the Harlem Research Institute, are presently conducting individual assessments of the 45 children enrolled in the project.

The other center-based project provides a structured infant-stimulation program and a developmental-affective program for toddlers. The Infant Development Supervisor conducts the infant program by making a "rough assessment of the baby" when the mother and child arrive in the morning. She describes the formal activities for the 19 infants, who participate with their mothers two hours a week:

> At about 9 o'clock we begin a planned period of interaction between the mothers and their babies. We plan exercises for the babies to be done by the mothers to supply kinesthetic stimulation and social interactions. The mothers are also taught to reinforce the behavior with a smile, talk, or pat. The exercises have been worked out for each age group of the babies. These exercises are designed to help the baby improve his own body mastery and allow the mother to spend this time with her child. Some of the exercises that we have done include arm and leg massages, and back and foot massages.
>
> I demonstrate each exercise on a baby and ask for a return demonstration by the mother under my supervision each time. At the time that each exercise is done, I offer an explanation as to why we do each exercise. I plan each activity for an active and then a quiet period. The babies are allowed to rest between each exercise. Also, we do some stimulation for development. These consist of simple games designed to help develop the visual, audio, sensory perception, emotional and social development. Each stimulation is explained to the mother and the expected responses that we may encounter are explained to the mother. I find that making an explanation step by step encourages the mother and helps her to participate in each exercise. By this I mean, the mother is presented with a very basic developmental psychology. The mother is continually encouraged to reward the baby with smiles, pats and even picking up the child and hugging. Each mother is supervised individually by me to be certain she does each exercise correctly.

Home-Based Programs

A southern university-based PCC has developed an experimental model for a program with disadvantaged Mexican-American infants. The plans include a three-pronged approach: (1) an "ecological-behavioral intervention program," (2) a parent discussion group, and (3) the provision of the "full array of services offered by the Neighborhood Centers Association." The project has 42 focal children, who are visited in their homes for an hour and a half a week, by a staff composed of professionals and graduate students.

Another cognitive stimulation type program that serves 68 focal children is located in a southern urban area and the home visitors are all nonprofessional. The family education aides have received extensive preservice and in-service training from child psychologists located in a nearby training hospital. A field research associate discusses the PCC program:

> The Family Education Aides visit the homes for three one-hour sessions each week for the purpose of "stimulating" children in the development of cognitive and psychomotor abilities with the aid of books, toys, and language activities. The skills and rationale of stimulation are also taught to the mothers so that they can increase their own effectiveness in adding to the development of their children. The mothers must be present during the visits of the FEA's, each of whom is responsible for work with about five families.
>
> As a part of the task the FEA's also talk with the mothers about their children--what they eat, how they play, toilet training, and their sleep habits, etc. The rapport between mother and FEA is also enhanced by the opportunity the FEA has to learn about problems the family is facing and to make the necessary suggestions to the mother as to where she might get help. The FEA's also take the initiative themselves on many occasions and get the help for a needy family. The FEA's link is with the home.

Three PCC's located in southern communities have incorporated structured home-visiting programs in conjunction with unstructured center programs. Ira Gordon's model has been easily adapted to the skills and life styles of the nonprofessionals who carry the programs to the homes of the PCC families for an average of an hour a week. A KAI observer says of one program:

> From all accounts, the Infant Stimulation provided by the parent educators is the most successful phase of the PCC program. Ira Gordon's Florida model is the basis of this program. I think the acceptance of the parents and the enthusiasm of the PCC staff can be best documented by the fact that the program is presently expanding the basic Florida sequence of stimulation exercises by a series of their own making. There is a local attempt to prepare materials for the next age group beyond that provided for in the Florida sequence of activities. The Child Development Supervisor is supervising this project, but the exercises are being developed jointly with the parent educators.

Home and Center Programs

The Gordon program seems to have been the most easily accepted model according to the observation of our FRA's. It seems to be better known in the South. Two of the southern home-and-center cognitive stimulation programs have adopted the model and adapted it to their needs.

A northern PCC located in a Black community has followed a variation of the Nimnicht Autotelic Responsive Environment,[1] for the four infants and 21 toddlers enrolled in their program. While the young children attend the center program, the mothers are paid to attend classes in child development that will prepare them for later jobs as child care workers. Our FRA reports that there are plans for the mothers to make home visits to 80 additional families in order to extend their learning to the community, although the PCC has not reported this plan as yet.

Another variation of a cognitive stimulation type of program has been developed by a southern urban PCC. The children's programs include a somewhat formal teaching period that is reminiscent of the Bereiter-Engelman approach. A general description of this program is made by KAI's observer:

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[1] Glen Nimnicht, Oralie McAfee, and John Meier, The New Nursery School (New York: General Learning Corporation, 1969).

1. Mothers bring children to the Parent-Child Center at 8:30 a.m. where they are given breakfast.
2. From 9 a.m. to 10 a.m. the children finish eating breakfast; the children older than 18 months watch "Sesame Street" on television while and after they eat.
3. From 10 a.m. to 10:30 a.m. a music session is held: all of the groups participate together during this period. In the final part of the period, the children walk around the room while one of the staff plays the piano; then they divide into their groups and return to their classrooms.
4. From about 10:30 a.m. to 11:40 a.m. the children participate in some group activity; there usually is a 15-20 minute free play period during this time, too.
5. From 11:40 a.m. to noon, the children wash their hands and prepare for lunch.
6. From noon to about 12:30 p.m. the children eat lunch. Each group eats in its own classroom.
7. After lunch the children sleep until 2 to 3 p.m. When the children wake up, they are given a snack. The parents call for the children at 4 p.m.

With the 6-month to 18-month-old children, the emphasis is on the development of motor coordination. These children work large picture puzzles, clap hands and dance to music on the record player, and play with toys that call for varying degrees of motor coordination. As far as I could tell, very few activities are directed toward the 6-month-old children. These children primarily observe the other members of the group.

The 18-month to 2-year-old children work slightly more difficult puzzles and paste triangles and circles, color, play with pegs, and in a very basic way are introduced to counting.

The two- to three-year-olds also paste triangles and circles, as well as rectangles. Painting and counting continue to be emphasized, and the letters of the alphabet are introduced to them. All these activities are continued with the three-year-olds, who also use finger paints and the flannel board.

The emphasis of the entire program is on sensory stimulation, language development, and social learning. There is no question that the children enjoy themselves

> at the center and feel relaxed there. Perhaps the greatest gains made by these children are in their social-emotional development.

Parent Attitudes

Eight of the 11 PCC cognitive stimulation projects have home-visiting components, which by many middle-class standards could be interpreted as an invasion of privacy. However, from all reports (and we must rely on the personnel who make the home visits for their impressions) the low-income parents seem to have accepted, and in some cases asked for, the home visits. Weikart and Lambie found that the low-income parents in the Ypsilanti project for preschool children wanted their children "to do well" and were accepting of the structured home-visiting program.

> ...there is little doubt that the mothers who participated in the project accepted home teaching with enthusiasm. Of course, there were wide differences in the individual feelings expressed by mothers. But in terms of permitting teaching to take place and of participating directly in the teaching session, mothers in this project were overwhelmingly cooperative. These mothers had a strong desire for their children to do well and, although a mother may have been totally ignorant of the correct steps to produce educational growth in her child, she was willing to learn.[1]

The fact that the PCC home visitors not only bring a program of infant education, but also some counseling and social services, may also make this kind of program desirable for lonesome and sometimes isolated mothers. One of the KAI observations of a southern urban cognitive stimulation type program illustrates this point:

> The home visit includes a great variety of activity. One mother talked about how pleased she was to have company--it gave her a legitimate opportunity

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[1] Weikart and Lambie, op. cit., p. 493.

> to stop doing housework and talk to another adult. Another mother who has been quite sick talked about the help she had received--i.e., the teacher picked up her surplus foodstuffs, got her medicine, drove her to the doctor.

The structured projects, as we mentioned before, not only are comfortable for the indigenous aides--that is, there are definite sequential procedures to follow--but are programs that present concrete form to the parents in terms of teaching techniques they may adapt and follow. Lavatelli has pointed out that the low-income parents of the Bereiter-Engelman project like it because "the children are taught something that will help them when they go to school, they don't just play."[1]

COUNSELING AND SOCIAL SERVICES PROGRAMS

Non-PCC Examples

Two examples of counseling and social services programs will be examined and used as models for comparison with similarly focused PCC programs. As we have stated before, the primary emphasis in this philosophy is in working directly with the parents in the hope of indirectly helping the children. Geismar describes one program, the Neighborhood Improvement Project (NIP) of New Haven, Connecticut, that worked with 45 "disorganized" families living in a low-income housing project between 1959 and 1964.[2] One of the objectives of the project was the improvement of social functioning of the families by effecting changes in "...such areas as family relations, child rearing, social activities, economic and health practices...." Group work and neighborhood services which included a nursery school, recreational services, and "intensive family-centered reaching-out casework" were provided by professional social workers. The treatment method was traditional casework intervention; it succeeded in showing significant movement in family functioning among the families "treated" as compared to the control group.

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[1] Celia S. Lavatelli, "Critical Overview of Early Childhood Education Programs," mimeographed (Urbana: University of Illinois, National Laboratory on Early Childhood Education, 1969), p. 8.

[2] Ludwig L. Geismar, "The Results of Social Work Intervention--a Positive Case," The American Journal of Orthopsychiatry vol. 38, no. 3 (April 1968), pp. 444-456.

Another counseling and social service type program is Project ENABLE (Education and Neighborhood Action for Better Living Environment).[1] This 15-month program was jointly sponsored by the Family Service Association of America (administrators of ENABLE), the Child Study Association, and the National Urban League, and was funded through OEO.

> Their aim, through ENABLE: to help the poor help themselves break through the wall of poverty surrounding them. Their concept: to focus on parents who, with fresh incentives and resources, could lead themselves and their families out of hopelessness and helplessness. Their approach: to combine the skills of casework, group work, and community organization through education and action. Their target: parents and families in selected hard core "poverty neighborhoods" in cities and communities across the nation.
>
> With 145 trained group leaders and 200 neighborhood social work aides, 300,000 parents became involved in discussion groups and social action. Such community problems as the opening of playgrounds, the paving of streets, the need for traffic signals and street lights, the enforcement of housing codes, and the need for adult education programs were discussed and, wherever possible, solutions were found. One worker from Kansas

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[1] Project ENABLE, a pamphlet published by Child Study Association of America, Family Service Association of America and the National Urban League, 28 pages, and Martin L. Burnbaum, and Mary Gay Harm, and Selma B. Ortof, The Content for Training in Project ENABLE (New York: Child Study Association of America, 1967).

> City, Missouri reported, "We have hundreds of examples where people have been helped to secure employment, medical help, training, education, rehabilitation, and legal aide. For every adult involved in these achievements, an average of five children were affected."[1]

The basic assumptions, principles, and values of social work as illustrated by the two programs just described and the PCC programs that will follow, are well defined by the following statement dealing with social work services for children:

> Parents have the primary responsibility for protecting the rights and well-being of their children in our society.
>
> Society has a stake in seeing that every child develops his individual potentialities, so that he may use himself creatively in and for society. It is in society's interest that children be reared under conditions that provide the requirements for personality development and social functioning in accordance with social expectations.
>
> Society can best discharge its responsibility for children by enhancing the capacities of parents to care for their children; by sustaining, strengthening, and restoring the parents' ability to fulfill their child-rearing roles, and, in this way, by preserving the home for the child, unless it is physically or emotionally damaging to him.
>
> Social work, with its particular values, knowledge, skills and methods, has a place among other professional fields in the attainment of desirable conditions for child rearing and growth, and in the prevention and amelioration of psychosocial problems that may affect family life, the rearing of children, the maturation process, and the social functioning of the child.
>
> There are a variety of settings in which the discharge of community concern and responsibility for children, and the professional practice of social work, may take place.

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[1] Project ENABLE, p. 11.

> Services concerned with the development and functioning of children require use of all available resources, and collaboration with other social institutions and professions that serve children. These services require involvement in social action programs to develop resources that may be lacking or inadequate.[1]

PCC Examples

Eleven PCC's have focused their programs on some form of counseling and social service theory. Eight of the projects are located in urban communities and four are directed by social workers.

A western urban PCC has developed a counseling and social services program for parents that focuses on casework and group therapy. A staff composed of four professional social workers, ten family workers, and a director of volunteers (nonprofessional) conducts a program for 90 families living in a city housing project. The Coordinator of Parent and Child Activities (with a master's degree in Rehabilitation Counseling) provides approximately an hour a week of exposure to a nursery school environment for from five to ten children while the mothers attend classes. (There are no child development workers, teachers, or teacher aides on the staff.) The children's program is not considered important to the goals of the PCC, since the emphasis is on support for, work with, and therapy (if necessary) for the parents.

An FRA observes:

> The largest and best developed aspects of the program are the home visits provided by the ten family workers and the supervising social worker. Families are visited on the average of once a week and these visits may vary in length ten minutes to two hours depending upon the circumstances and the needs of the family.
>
> The social worker reports that when some crisis arises a family may be visited two or three times during the week.

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[1] Child Welfare League of America Preliminary Statement on Social Work Service for Children in Their Own Homes (New York: Child Welfare League of America, 1968).

> The purposes of the home visits as described by the social worker are:
>
> --to develop the relationship,
> --to provide informal counseling,
> --to provide information and referral, and
> --to provide a liaison with other PCC programs.
>
> In addition to these home visits by the family workers, considerable counseling and psychotherapy are provided by the social worker on the staff of the PCC and by other agencies. Families are referred to a general hospital for both individual and group counseling. A Spanish-speaking therapist meets with two groups of Spanish-speaking mothers for weekly group therapy sessions at the PCC. Both crisis intervention and long-term therapy are being provided for PCC families.

A southern rural program works with "hard-core" families that public health nurses and workers have described as "the worst" and "most in need." Many of the families have no running water in their homes and KAI's observer found the children "more poorly clothed and unkempt" than children in other PCC programs. Through a program of home visits and individual contact with the parents our FRA observed:

> The total effect of work with mothers has been impressive. Once they made some clothes, learned to dress a bit more adequately, and cleaned up to attend the center or a PAC meeting I could not readily tell them from staff. Many painted their homes, made curtains and linens, or otherwise improved the houses in which they live. These activities probably made the center's efforts in behalf of their children more acceptable to them. As a whole, mothers appear to accept and to be pleased with the experiences provided for their children and they appear to have gained some understanding of the relationship of early childhood experiences to adult performance.
>
> An effective program for mothers may be essential to maintaining contact with a family and it is undoubtedly a major factor in the development of cooperation for optimal development of the child.

A midwestern PCC has developed a walk-in clinic in conjunction with the center. The FRA reports:

> This offered crisis intervention and supportive treatment mostly and served as a diagnostic and referral program for those families who needed help and "walked in" to ask for it. There was also some information giving and suggestions regarding how to help the child. The program was operated by two psychologists on a part-time basis and two psychology aides who were being trained to give some tests and to do interviewing. The theoretical orientation was eclectic in nature rather than following any one school of thought.

PARENT EDUCATION PROGRAMS

The Parent Education theory has within it two approaches: (1) education through observation and "volunteer" participation with the children in the center, followed by seminars, lectures, or discussion groups dealing with child development, child-rearing techniques, or subjects relating to the growth and development of children (note that the focus is on the child rather than the parents); and (2) education through direct employment, which involves the "New Careers" philosophy using the "helper therapy" principle outlined by Reiff and Reissman: "Since many of the nonprofessionals recruited for anti-poverty programs will be school droputs, former delinquents, long-term ADC mothers and the like, it seems quite probable that placing them in a helping role will be highly therapeutic for them; and as the nonprofessionals benefit personally from their helping roles they should become more effective as workers [mothers, in the case of PCC's] and thus provide better help at a higher level of skills."[1]

Non-PCC Examples

Hoke describes a program called "Project Pre-Kindergarten" developed by the New Orleans public schools in 1965-66 that stressed the importance of beginning with problems of immediate concern to the parents. Families were invited to participate in bi-monthly meetings held at the center, which took the form of large lecture meetings, viewing of films, witnessing demonstrations of educational techniques, or small "kaffee klatches" where informal discussions were held dealing with problems of children. Study groups and workshops were formed around subjects "...devoted to family needs, such as budgets, homemaking tips, information dealing with legal and social services; aspects of child growth and development, such as the early stages in child development, child rearing, and discipline; physical needs, such as nutrition, hygiene, and the identification, prevention, and treatment of childhood diseases; and various phases of the educational program, such as school goals, story-telling techniques, and games and finger plays for carry-over experiences in the home."[1] Community resource people were brought into the meetings as often as needed and teachers were included in order to maintain a consistent approach between the classroom and the meetings. Parents were encouraged to participate in the classroom and to accompany the children on field trips. Teachers, social workers, and nurses visited the children in their homes at least twice during the year. The Pre-Kindergarten Project was considered successful and "in future projects, parents will be invited to serve on planning and advisory committees."[2]

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[1] Robert Reiff and Frank Reissman, The Indigenous Nonprofessional, Community Health Journal Monograph Series, no. 1 (Lexington, Mass., 1965), p. 9.

Another program of the parent education type is the Parent Preschool Child Project of the Los Angeles City Schools, developed by Evelyn Pickarts and Elizabeth McCandless. This project of 1965-66 provided a nursery school experience for 38 classes of 1,093 adults and 1,705 children in poverty neighborhoods once a week. Mothers were required to attend the classes with the children, which were each staffed by a certified teacher and a community parent education helper. "Teachers worked with the children as a demonstration for mothers and in discussion groups with mothers to clarify the needs of children, the methods of meeting those needs, and how mothers could use the demonstrated teaching techniques and develop a home environment conducive to learning and healthy personality development."[1]

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[1] Gordon Hoke, "Involving Parents in Programs of Education Reform," mimeographed (Urbana, Illinois: ERIC Clearinghouse on Early Childhood Education), p. 6.

[2] Ibid.

Another parent education type of program is described in an ERIC newsletter that begins with "Why not have mothers be the teachers in Head Start?" Mothers in Bent and Crowley counties, Colorado teach Head Start children in their own homes with the assistance of one other mother-teacher, twice a week. They never teach their own children and the ratio of teacher to child is kept down to 1:2. The mothers receive regular Head Start training plus an ongoing, once a week training session. After one year of operation test results show greater gains for the children in this program than for the control group enrolled in a "conventional" Head Start program. "Improvement in intangibles, such as parent attitudes, self-confidence, and social competence, are also reported."[2]

PCC Examples

There is a wide variety of PCC parent education type programs. One midwestern urban PCC has no program for children and is concentrating on 14 young mothers or mothers-to-be in a training program that will prepare them for day-care positions after the birth of their babies. They are paid to attend the classes and it is still unclear whether actual jobs are being provided for the young mothers. The course material for the "Family Aide Training Program" consists of infant care, nutrition, growth and development, and related classes presented in the form of lectures and field trips, as well as a program of arts and crafts. The KAI observer says:

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[1] "Parent Preschool Child Project #7-96, CAL-CAP," mimeographed (Los Angeles: Los Angeles City Schools).

[2] ERIC, vol. 4, no. 1 (Urbana, Illinois: ERIC Clearinghouse on Early Childhood Education, January, 1970).

> The girls (i.e., client mothers) have no doubt learned a great deal in their 15 or so months with the PCC. In addition to crafts work and sewing (and typing for some) there was much gained from participation in the Family Aide Training Program.
>
> It must be assumed (the only "evidence" is in the comments of the girls themselves) that their relationships with their children and other family members, have been affected by the PCC experience, and in a positive manner. Also, the experience, including their involvement in the difficult organizational development of the PCC, has provided a valuable perspective for these young ghetto residents, in terms especially of their perceptions of how they might improve their lot, and what kinds of people and problems they might encounter.

Another western urban PCC provides a work-study course for 19 mothers, four hours a day, five days a week, for which they are paid $125.00 per month. While the mothers attend the classes that will prepare them to become day-care aides or assistant nursery school teachers, their children attend a center that doubles as a program for children and an observation class for the parents-in-training. The plans for this PCC include an outreach program, which involves the 19 trainees going to the homes of 80 families located nearby to demonstrate the methods of infant and child care they have just been taught.

Other PCC projects have hired the mothers as teacher aides and have been unable to provide training. A KAI observer illustrates the more positive effects of this situation:

> The aides seem to get along well with the mothers. They are neighbors and fellow mothers. When a mother comes in she and the aides sit and chat over coffee. The aides do not have any special or professional theories about child development that might antagonize the mothers. They are just mothers from the neighborhood that take care of the women's children during the day. They are not trying to do anything with the children that the mothers don't understand or mistrust. Furthermore, they are not trying to educate the mothers. This

> saves a good deal of friction, I suspect. The whole staff is eminently nonprofessional, and while being a handicap, this fact probably avoids some of the troubles encountered at other centers.

One way to educate mothers is to hire them as staff. A southern urban PCC has hired 20 mothers to become infant educators in the home-visiting program and provides 35 hours a week of day-care services for their children. The infant educators receive an intensive training program in a cognitive stimulation approach, and then, in turn, provide four to five hours of individual programming for 67 children in their homes. Problems have arisen from the fact that 20 mothers are provided with jobs and day care for their children, while other mothers in the same small ghetto receive only home visits; in addition, the question of confidentiality between client and worker has been raised by some residents.

The most frequently used parent education method used by PCC's involves a period of group discussion following participant observation of children. Fifteen PCC's have incorporated some form of this process in their programs. Nine of these PCC's are directed by persons with degrees in education.

One typical program is described by an FRA:

> Parents are not permitted to bring children to play groups and leave. One day a week they are supposed to be in the playroom with aides and teacher, learning to play effectively with their children. Sometimes the teacher or child development coordinator discusses aspects of cognitive growth and child care with them during this session. On the second day of the week the parent stays with the play groups through the snack which is offered to children and mothers very soon after they arrive. She then goes to the parent lounge for any one of a number of possible activities.

Many of the PCC's have included sewing, nutrition, crafts, and other homemaking activities into their programs in an attempt to interest mothers in coming to the center. Usually there is child development, discipline, or some other form of education mixed in with the homemaking classes.

It is not always possible to involve the mothers in this kind of program. Our KAI observer in a southern urban community illustrates this point:

> The most serious problem in the operation of the nursery program has been the lack of full cooperation of the mothers in working as aides in the nursery. The teachers have complained that the mothers often resent helping in the nursery as an unwarranted imposition on the time they would rather spend with the other mothers. Many times the mothers will leave the nursery and strike up conversations among themselves in the hallway. Some mothers have also reduced the effectiveness of the teacher-child relationship by "using the teacher as a bad wolf symbol." The staff has attempted to meet this problem by small group discussion and better scheduling of the mothers' nursery assignments. The problem is a serious one since the mothers' nursery experience is an integral part of the program's attempt to inculcate better child development and management skills.

Benefits of Counseling and Social Service and Parent Education Programs

By involving the parents either in work or observation of the children, or in self-help projects for themselves and their children, there can be little doubt that the community will benefit. We are in no position to evaluate the relative values of these programs, but would like to make some observations, based on reports sent us:

Those programs that are consistent in their approach seem to be the most effective. Parents are less likely to be confused by conflicting views on child care when the orientations of all staff members within a center are the same.

Those programs that provide outreach services in the homes, reach many of the "hard-core" families who would be unable to attend observation or classes in adult-education in the center, and indeed, care little about anything but surviving. This kind of program is well described in The Drifters[1] and the payoffs are small compared to those providing services for the more upwardly-mobile poor.

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[1] Eleanor Pavenstedt, ed., The Drifters (Boston: Little, Brown and Co., 1967).

IMPACT ON THE CHILDREN

There is a general impression on the part of the KAI observers and staff members of the PCC's that the children have benefited from the program. The impression is gathered from interviews, the records of some centers, and on-site observations rather than any hard testing data. One University Affiliate did test children in a northwestern PCC and, according to the minutes of a PAC meeting, made the following findings:

> Improvements in language, emotional, and social development had been found in PCC children. The home situation looked 20 percent better after starting in PCC. This includes home stimulation--helping the child to think, and providing more learning experiences. Vocal improvement was 25 percent from the first to the second test three months later, and emotional improvement was 33 percent. The Denver Developmental Screening Test also showed improvement from the first test to the second test three months later.

A sampling of typical observations follow:

--A southern, urban, cognitive stimulation, home-and-center program:

> What I have are anecdotal data which suggest that the actual appearance of the homes of PCC families is neater, cleaner, more attractive. That ways of working with children have moved toward parents being more tolerant and concerned, that meal planning is more organized and built around nutrition, and that parents are buying educational toys and games where these were formerly lacking. One mother said to me, for example, "We don't have any now and we've never had any, but after Christmas we sure will." There seems to be a change in disciplining practices in which parents are now seen as using distracting techniques instead of spanking. They seem to behave less impulsively and more thoughtfully. One of the changes noted in those who do come to the center is that they now seem more willing to be responsible for other people's children rather than simply their own.

--A northwestern, rural, developmental-affective, center-only program:

> The homes and the children are kept cleaner, the parents' self-image has improved, their relations with their children are better, they are more interested in the development of their children, and they are somewhat more willing to make use of community resources than they were before.
>
> The children have become less docile. Parents, and teachers in Head Start, have been asking, "What are you people doing at that center? The kids that come from there won't be still anymore, and won't mind us like they used to." The effect of this change in children is sometimes to create new strains within the traditional Mexican-American families, especially if father or uncle or grandmother have had great power in the family before, but now are not a part of the new things the children are doing with the mothers.

--A midwestern, urban, developmental-affective, home-day-care program:

> Parents have become more aware of their children's educational needs. They are seeking ways of enriching the lives of their children and of raising their standard of living.
>
> The PCC program has helped the parents become more effective in the lives of their children by helping them to actively bring about a change in their lives rather than simply "letting them become victims of changes."

--A southern, urban PCC combining a cognitive stimulation, home-visit program with a developmental-affective, center program:

> The major change for the better noted in families has been in the parents' attitudes toward their children. Parents are decidedly more verbal with their children and show more concern about the child's need for personal space and freedom of movement. Recently a staff member discovered a mother clearing out a whole dresser drawer of her own things so that the space could be used by her child for storage of his playthings. This mother had not been noted previously for having this kind of concern for her children's needs.
>
> Both parents and staff seem most pleased with the progress the children have shown. There is a keen awareness on the part of the families that what is being done for children in the program will have a positive payoff in later years, particularly in school progress. Many parents have expressed open regret that their older children did not have this opportunity.

--A southern, rural developmental-affective program that combines a center program with a group-home experience with Alternate Home Mothers:

> Mothers are spending more time talking to their children. They report that the children force them into this role because the youngsters have learned from aides and their center teacher to expect interaction with adults. Some mothers are pleased with the child's changing role. I do not have any idea how many mothers have been influenced to initiate play and language development.

--A Rocky Mountain, rural, developmental-affective, home-visit and center program:

> Involving mothers intensively is of utmost importance in the overall program scheme, which is that a program of this nature cannot help a child unless it first concentrates on meeting some of the parents' basic needs. One of the needs that these centers have been most successful in meeting is that of an improved self-image of the parents. It has had significant success in helping overcome feelings of depression and isolation of many parents and, in many, has helped develop latent leadership qualities and creative talents. An improved self-image, more self-confidence, and a happier outlook on life have, in turn, made more effective parents of these people. Children of parents who have been highly involved in the program have experienced more measurable progress than the children in the relatively uninvolved families.

Only in three programs which minimized children's programming and emphasized the social service work with the parents was there any question of benefit and impact on the PCC children. Otherwise, it was unanimously reported by the field research associates that the children were improved in verbal skills, social adjustment, physical appearance, involvement with adults or their peers, and in a variety of other appropriate ways. This agreement contrasted with the critical examinations of staff, training, supervision, facilities, lack of appropriate programming, and/or difficulties in beginning the children's programs. The impact on the children in the PCC's is especially remarkable in view of the brief existence of the projects and the centers' numerous problems.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

1. The facilities available in low-income areas for infants' and toddlers' center programs are inadequate. If there had been strict code enforcement applied uniformly in urban and rural areas, fewer centers would now be in operation.

2. There has been a concensus among KAI observers that the children's component of the PCC program is weak due to the general lack of knowledge in the field of education for children from birth to three years of age. Until recently the group care of infants and toddlers has been frowned upon by experts in the United States and now throughout the country there are only a handful of authorities available and experienced in this area. Universities and colleges with courses dealing with children from birth to three years of age are few and distant from most PCC's. The need for an ongoing training program dealing with the very early years of childhood for professionals and nonprofessionals is manifest.

3. Observations and reports have indicated that most PCC children's programs have been well received by parents and children. FRA's have observed the increased use of language by the PCC children. Since the first-year study is one of inputs, we have no systematic information on how effective the PCC programs have been in the areas of cognitive and language development, self-image, and social skills of the children. We do know that a variety of interventions can improve the intellectual skills of the children. But, says Miller,

> ...the real trick is to maintain those gains over a period of time so that the usual picture of progressive decline does not emerge, thus, the strategy of a broad program of skill development with a fundamental stress upon the sustaining motivations and support systems with the family to insure continued development. The conclusion of whether or not the approach is sound,

however, must wait for several years to follow the children in their careers.[1]

4. The technique of hiring parents as members of the teaching staff has been effective in changing the quality of child-rearing patterns among some of the poor, according to our reports. Although problems do occur and costs are high because of this hiring pattern, the results seem to be worthwhile.

5. The director of the PCC is not only responsible for the children's programs, but is also responsible for the leadership, supervision, and coordination of staff. Our FRA's have indicated that the tone and quality of programming for children by the staff is directly affected by the personality, administrative abilities, sophistication in community organization techniques, and the ability to stand frustration and conflict on the part of the director. The amount of support provided by the University Affiliates and consultants has been uneven but the needs remain great.

6. The goals of the PCC's have been approached in different ways depending on the location, community resources, staff qualifications, PAC direction, ethnic make-up of PCC families and the philosophy or theoretical persuasion of the director. In many cases, PCC's are isolated from worthwhile stimulation and interchange with others sharing similar goals.

7. Parents involved in the PAC's have been unclear as to their responsibilities and authority in terms of the children's program.

Recommendations

1. Greater provisions should be made for renovation and building costs in view of the inadequacy of available facilities. These costs tend to be one-time costs incurred at the beginning of a program and allowances should be made for them in addition to normal operating expenses.

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[1] James O. Miller, Diffusion of Intervention Effects in Disadvantaged Families (Urbana, Illinois: ERIC Clearinghouse on Early Childhood Education, 1969), p. 17.

2. In view of the limited knowledge and capability available concerning children from birth to three years of age, greater efforts should be made to increase this capability and to disseminate it to those in PCC's who need it. Increased training and technical assistance materials for professionals and nonprofessionals have to be developed. They also have to be made available in appropriate ways. Universities, colleges, private organizations, state and municipal governments all could be encouraged to enter this area of increasing need by federal government direction and support.

3. This study does not focus on the impacts of the program on the children because the program is still in its formative stages. The impact on the PCC children should be followed for several years. An output study examining the effects of different kinds of interventions should be instituted and tied in with Head Start and Follow Through programs.

4. Continued employment of parents as staff members should be encouraged. More training should be provided for these staff members and training should be designed so that it is consistent with the life and learning styles of the parents.

5. A more complete and sophisticated system of technical assistance is necessary to support PCC directors and staffs in their very varied responsibilities. A great variety of assistance should be readily available from persons who are not only expert but also sensitive to the groups they are working with.

6. Working meetings of the staffs of several PCC's with similar goals and problems should be encouraged. Such meetings could involve as resource personnel experts in fields particularly crucial to the programs of the PCC's in the meetings. Staff participation in such meetings in workshops, demonstrations, and discussions is considered very important.

7. A clear and concise statement of the duties and authority of the PAC's concerning the children's programs should be developed and distributed. Training programs for PAC members should also be started so they can fulfill their roles more effectively.

CHAPTER VIII

PROGRAMS FOR PARENTS AND OTHER FAMILY MEMBERS

INTRODUCTION

This section describes the programs developed by the Parent-Child Centers to meet the fourth criteria specified:

> Parent activities designed to strengthen their understanding of child development; competence as family managers; skills essential to making a living, including maximum opportunities for employment within the PCC; self-confidence and self-image as parents; intra-familial relationships between husband and wife (where both parents are present) and between parents and children; and definition of the male role within the family.[1]

Centers developed widely differing programs to meet both the criteria established and the special needs of the local situation. Not all centers developed programs in each of the categories. This section presents a description of the types of activities developed, the number of mothers, fathers, and other family members participating, and what the staffs and families learned about developing such programs. Three centers experimented with three different plans for paying parents to motivate them to attend and these experiments are also described.

Data reported in this chapter are compiled from a variety of sources. The major source utilized for defining the programs developed and calculating the number of family members attending are the Program Services Reports of the PCC center directors. This report has been used except for the ten centers whose directors failed to complete the report. For these ten centers the two major sources of information are the reports of the KAI field staff and the refunding proposals. These latter sources have been used also to augment the data reported by the center directors. In a few cases, centers forwarded copies of their Management Information System reports, and information from these has been utilized to provide as complete a picture as possible of the activities developed for the parents. The assessment of how programs were accepted by families has been abstracted from the reports of our field staff.

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 4.

PARENT ACTIVITIES DESIGNED TO STRENGTHEN THEIR UNDERSTANDING OF CHILD DEVELOPMENT

Program Description

Centers have developed two general categories of programs to meet this criterion:

1. Programs for the children themselves, conducted at home or at the center, in which the parents (mainly the mothers) observe for the purpose of learning about principles of child development and child management. Programs such as these, in which the mothers either assist or observe in their children's play groups, have been developed by all but ten of the centers, and are discussed in the previous chapter.

2. Adult-directed programs, whose purpose is to teach parents about child development using adult education techniques. While at times guest lecturers or consultants have used observation of children's play groups as a teaching tool, these programs are generally more structured, didactic, and academically oriented. The courses usually meet on a regular daily, weekly, or monthly basis for a specified period of time such as a semester or six weeks.

This second category of adult-directed programs designed to increase the understanding of child development was reported as provided by 49 percent of the Parent-Child Centers. A total of

564 mothers, or 31 percent, of all enrolled have taken such courses. Fifty-one of the fathers and 12 other family members were reported to have attended these courses.

The centers utilized a wide variety of methods for presenting the child development courses, depending upon the location of the center, the arrangements possible for the center, and the availability of professional resources in the community. Some courses consisted mainly of lectures; others used films, discussions, and other routine classroom techniques; and others, as cited below, used really innovative teaching techniques. In general, the rural communities have had to rely more on their own staff to teach these classes, while the urban areas have had a wide variety of consultants and specialists from universities involved. The following were among the more interesting programs provided by the PCC's.

> --In a rural PCC, a class in child development and another in child discipline were taught by staff from the University of Illinois.
>
> --In another rural center the University Affiliate provided a three-month project designed to teach mothers how to increase the language level of their children. Staff and mothers were trained to administer a language test, to modify children's language behavior, to encourage them to talk more, and to assess changes in the child's vocalization. According to the University Affiliate, 90 percent of the 20 children involved showed improvement as measured on the Gesell.
>
> --In a western PCC, parents attended a course in child development provided by a junior college; the center provided baby-sitting for their children while the mothers were in class.
>
> --In a southern center, the Mental Health Institute provided the parents with a training program designed to demonstrate the simplicity and effectiveness of using behavior modification techniques to bring about language improvement. The mothers showed interest in learning about the use of rewards to encourage desired behavior and tried to carry out the reinforcement schedule but did so in a nonvigorous manner, in keeping with their life style.
>
> --In another center, the staff of the PCC met with the mothers to discuss their children's problems.

--In an Appalachian PCC, mothers met at the center and discussed child rearing and community problems.

--In an urban center, mothers gathered to discuss child rearing while making useful items for themselves and their children.

--In a northern center, a ten-week program was developed for 13 teen-age mothers. Described as a Family Training Program, it met for three hours daily, five days a week and included lectures, trips to a hospital delivery room and nursery, observation of infants, discussions, lectures and films such as "Developmental Diagnosis" and "The Newborn." The mothers received a stipend from the Neighborhood Youth Corps for attending the series contracted for by the PCC.

Discussion

Certainly many of the PCC's can be regarded as successful in their attempt to get the attendance of parents at classes in child development since nearly a third of the enrolled mothers have attended such classes. Considering the limited enrollment of men in regular college courses in child development, even the participation of 51 fathers can be considered an achievement. As the year progressed, many centers learned a great deal about how to secure the attendance of parents in center programs. What was learned about recruiting parents to this and other classes is summarized at the end of this chapter.

Gaining the attendance of parents at scheduled classes is only the first step in achieving the stated goal of "strengthening their understanding of child development." This stated criterion is in fact an intermediate goal--the real expectation is that the increase in understanding of child development will bring about a change in the child-rearing method. The crux of this issue has been clearly articulated by James Miller.[1]

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[1] James O. Miller, Diffusion of Intervention Effects in Disadvantaged Families (Urbana, Illinois: ERIC Clearinghouse on Early Childhood Education, 1969), p. 21.

> Another question that often arises in discussions of intervention research is that of values. The question is often raised by some well-meaning but misguided person that we are changing the value system of our families to that of the middle class. In working with families from disadvantaged backgrounds, we have taken the stand that there is nothing quaint about poverty, nothing socially uplifting about hunger, nothing self-rewarding about hopelessness, nothing inspiring about ignorance, and nothing culturally valuable about despair. We have assumed that to have the freedom of choice one must have the skills to make decisions. If one is going to have the right opportunity, one must be prepared adequately to take advantage of it. To be socially competent, one must be able to compete effectively for the rewards society has to offer. One must also be able to forge new roles which enhance oneself. This intervention research then is value-oriented in the sense that it is based on the notion that social competency emanates from the development of adequate cognitive skills and the sustaining motivational states upon which self-development depends.

Child-rearing practices are central to the life style, the attitude and belief system as well as the self-concept of all people, particularly mothers. To be wrong, to be judged wrong, or to feel that one is being judged wrong about how one is raising one's children is a threatening experience. It is especially threatening to low-income mothers who have little to show for their lives but their children. It is to be expected that the programs provided to teach child development which have the secret and unarticulated agenda of changing the methods of child rearing are not always met with great acceptance by the parents. Only those program planners and implementers who have shown an awareness that the purpose of the child development program is to change the attitudes and practices of the families are able to develop programs with sufficient sensitivity and skill that the information introduced may be accepted. While parents have attended a large number of classes in child development, field reports indicate that not all PCC's have been successful in getting their message accepted. Those centers which have shown awareness that they are trying to change attitudes and have utilized well-established techniques to do so have been more successful in getting their communication across.

The first and perhaps the most pervasive and deeply held attitude that child development trainers are trying to overcome and change is the sense of powerlessness to affect the behavior of their children that many low-income parents share. Our field associates have reported, as have previous observers, that many of the parents seem to feel that the behavior of their children is a matter beyond their control; that children are born with fixed traits and parents are powerless to guide or direct their behavior. Many seem to feel as one PCC mother, who said, "When you has children, you take potluck. You get some good and some bad."

Centers have met with varying success in trying to convey the message that parents can influence the behavior of their children, and that further, the method of discipline used is important in determining the outcome of the attempt. From the point of view of many professionals in the field of child development, "discipline" is a broad concept including any plan to elicit desired behavior, and may consist of structuring a situation, establishing contingencies, using tangible rewards, or using praise and approval. From the viewpoint of many PCC parents, discipline is always physical punishment, or consists of yelling, threatening, or belittling children in the hope that some undesirable behavior will be stopped. How children are to be disciplined in the PCC's has been one of the most frequent areas of disagreement between professional staff and parents.

The issue of how children are disciplined can be of utmost importance since the punishment is sometimes so harsh that it goes beyond the category of physical punishment and into the battered-child syndrome. In one urban center, the teacher told the child psychiatrist evaluating the program that some mothers even spank their infants. In another urban area, a PCC baby died of suffocation when his father tried to stop his crying by putting his hand over the infant's mouth. In extreme cases, the discipline used by the parents may determine the survival of the children, but even in less extreme cases it is of great significance as pointed out in a speech by Dr. Charles A. Malone[1] about the development of children from multiproblem families:

> Even brief consideration of their environment underscores the kind of danger these children are exposed to early and continuously in their lives.
>
> They must bear the brunt of harsh punishment and parental loss of control. They are yelled at, slapped and beaten in inconsistent, confusing ways. They are punished for accidents as well as for intentional naughtiness, for things they haven't done as well as things they have done; even for things that previously and on other occasions they have been encouraged to do.

In attempting to meet the criterion of increasing parental understanding of child development, centers have undertaken the very difficult task of introducing methods that often conflict sharply with deeply held beliefs and values, and it is therefore essential to examine which methods of communication have been successful.

Parent Education Methods

Field research associates were almost unanimous in reporting that the effective methods of training both staff and parents were through demonstrations, workshops, and other participatory activities rather than lectures or didactic methods. This is by no means a new finding, but since so many centers still are repeating the ineffective method of "telling" rather than "showing and involving" this point must be reemphasized. There are several important examples of how new techniques for disciplining children were demonstrated in various PCC's:

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[1] Charles A. Malone, Speech presented at the 1965 Annual Meeting of the American Orthopsychiatric Association, American Journal of Orthopsychiatry, vol. 36, no. 1, p. 6.

--In a southern center the mothers observed university staff demonstrations of how behavior modification techniques could be used to encourage language development. While the mothers did not carry out the reinforcement schedule in any systematic way, they did learn that their children's behavior could be influenced by rewards as well as punishment. As one mother reported, "My kids mind more when I give them a cracker than when I hit them." The mothers who participated in this training learned from firsthand observation of their own children that the methods demonstrated by the psychologist helped them manage the children. Like people everywhere, these mothers were willing to repeat what worked.

--In a rural PCC, college students carried out a demonstration designed to show that the mothers had the power to reinforce desirable verbal and nonverbal behavior in their children. The mothers told the field associate that they had learned about the value of praise for the first time in dealing with their children. The staff at this center confirmed that after the series of demonstrations the mothers did not resort to hitting or punishing responses as frequently. During the course of the experiment, the mothers also learned that while food and other tangible reinforcers are used at first, it is soon possible to use words and other signs of approval as reinforcers.

--From another PCC, the field researcher reports that she observed a gradual change in the mothers' relationship with their own children. Initially mothers threatened their children with dire results (Mind me, or I'll tear your eyes out) but after observing the methods the teacher used to manage the children in the nursery, a gradual shift came about in techniques used by the mothers.

What the field associates report, then, is simply that the mothers are empirical: what they see is effective; they are willing to try it for themselves. Effective is that which gets results not some theory articulated by a professional.

The Communicator

Here again, it has long been known that a message is more apt to be accepted when it is delivered by someone who is perceived as a part of the group rather than an outsider, or at least where the communicator is acceptable to the group. Those consultants who were carefully briefed by the staff as to the unique needs, problems, conditions, or life styles of the PCC families were met with more acceptance. Those consultants or trainers who were presented to the PCC mothers without any prior sensitizing often met with hostility and rejection.

Staff and Group Support

In order to gain support from the parents it is necessary that the programs and techniques demonstrated by sensitive and well-oriented consultants or professional staff be well supported and reinforced by the nonprofessional staff. Since these nonprofessionals are frequently from the same population as the families and have a greater acceptance and ease of communication, and since they also have more frequent contact with the mothers and the children, it is essential that the training both begin with and be accepted by them. In those centers where the nonprofessional staff has not accepted the theories presented or articulated by the professionals and consultants, they have short-circuited the whole child development program. These nonprofessional staff are the crucial link in the program and in obtaining group support from the mothers.

Summary

Many centers were effective in getting parents to attend classes in child development. These classes were better received by the parents when:

--the techniques used to present material were observation, demonstration, or participation rather than didactic methods;

--the consultant or staff person delivering the message was both sensitive to the group and accepted it; and

--the message was both accepted and reinforced by the nonprofessional staff of the PCC.

PROGRAMS TO DEVELOP COMPETENCE AS FAMILY MANAGERS

The task of family management is perceived by society as well as by the PCC's as a part of the role prescription of mothers; as Table 17 indicates, of the 1,783 participants in these programs, all but 21 were mothers. It would, of course, be unlikely for fathers to take part in sewing, cooking, or nutrition classes, but some might be expected to have an interest in matters of shopping, budgeting, or improving the home.

TABLE 17

Parent-Child Center Family Management Programs

	Percent of Centers Providing Program	Number of Participants			
		Mothers	Fathers	Other Family Members	Whole Families
Sewing	71	469	0	7	0
Nutrition	37	322	0	10	0
Cooking	46	313	0	0	4
Consumer Education	34	262	0	0	0
Menu Planning	29	200	0	0	0
Purchasing Clothing	6	61	0	0	0
Home Improvements and Repairs	23	115	0	0	0
Rat Control	3	20	0	0	0
Totals		1762	0	17	4

Sewing and Cooking Classes

Of all activities provided for family members other than for the focal children, sewing was offered by the largest number of centers and participated in by the largest number of mothers. In many cases the first activity developed when the PCC opened was the sewing classes. These classes served as an instrument by which mothers could be drawn to the PCC and could meet the staff and become acquainted with the potential services of the PCC.

Sewing classes were popular among mothers for several reasons, some obvious, others not quite so obvious. For the mothers who already knew how to sew, these classes provided a welcome opportunity to use sewing machines and to obtain free yardage and other materials. In an afternoon an experienced seamstress can produce a much needed item of clothing for some member of the family. Low-income mothers who seldom can give things to their children or husbands find in the sewing class the opportunity to produce a gift that reflects not just an object, but also their efforts and love. In return, the mother sees the pleasure of her husband or child and is quickly rewarded for her efforts. When the mother sews something for herself, she feels the pride of accomplishment as well as the lift most women get from owning a new article of clothing. Thus sewing fulfills the economic as well as the psychological needs of the mothers.

Both staff members and mothers gain from the discussions that take place during the sewing classes. Mothers, often lonely and isolated, very much enjoy the opportunity to get out of the house, meet, work, and talk with other women while their children are cared for in the nursery. At the PCC they find companionship as well as the opportunity to learn. These classes provide the staff with the opportunity to learn more about the mothers, their levels of skill, their hopes, their problems, and their expectations of the PCC program. The conversation of the mothers during these sewing classes provides many useful clues to sensitive staff members for the development of programs as well as providing an opportunity to establish rapport with the mother.

As soon as the mothers began attending sewing and other classes in home management, it became obvious that the curriculum initially planned would need adaptation for the PCC parents. During the planning period many PCC's developed slight variations of high school or gas company home economics classes; these were quickly revised once the PCC families were met and their living conditions fully realized. Home visits by staff assigned to teach home management resulted in many changes in initial plans. As one observer wrote:

> A cooking class held in one of the PCC homes proved to be of great educational value to the staff as well as the PCC mothers. The staff learned of the hardship of meal preparation with a very limited supply of cooking utensils and very little water, which had to be hauled from a spring. On the other hand, the mothers learned that really good meals can be prepared from commodity foods.

Another wrote that the home economics teacher who had taught previously in a high school had planned a unit on how to set a table properly. This she quickly changed when she found that the mothers did not have the silver, dishes, or other equipment with which to se[illegible].

Home economics staff members also had to tailor their initial plans to meet the level of skills of the mothers who are far more heterogeneous than the average group of students. While some mothers are already expert seamstresses and some mothers have been employed as cooks, others have never cut cloth with scissors. One center introduced quilting and hand sewing to a number of mothers before they could begin to teach work at a machine. Another center found that cooking from recipes could not be taught to mothers who did not know how to count, measure, and read and that these basic skills had to be incorporated into the cooking class. A number of Parent-Child

Centers have developed cook books with low-cost menus and a minimum reading level.

Center facilities have hampered the implementation of some of these classes at various centers. Few PCC's have kitchens large enough to allow for the simultaneous preparation of meals for the children in attendance and the involvement of any sizable number of mothers in learning cooking skills. One Parent-Child Center in the South made plans in the second year of its operation to equip a second kitchen fully for the sole purpose of providing training for the mothers in food preparation.

Because the activities organized to develop competence in home management have been so popular with the mothers, they provide the staff with the opportunity to integrate a number of other services with these activities, and to create some really innovative activities. When one PCC found that a large number of children were borderline anemic, it arranged for the nurse to attend sewing and cooking classes to emphasize to mothers the importance of eating habits and selecting low-cost foods which provide iron to reduce the incidence of anemia. Another PCC has the child development supervisor sit in on the sewing class since this provides an excellent opportunity to do informal counseling with the mothers.

Other Programs

While most of the activities and classes in home improvements and repairs revolve around how to fix up furniture and do inexpensive home decorations, one center has developed a unique plan. It has employed a whole category of staff known as "Environmental Enrichment Aides" who describe their jobs as "to help the mothers improve the living conditions of the families." This center has also employed a handyman who works out of a shop at one of the PCC's two centers. In the shop he makes screens, storm windows, and small items of furniture and makes minor repairs. In this particular center the parents have helped repaint one another's homes; nearly half of the families have had their homes repainted to date.

The inclusion of a program for the control of rats in a set of activities designed to develop competence as family managers might be questioned, but in the homes of many of the PCC families this is an essential skill.

Summary

Other than the programs for children under three, these homemaking and consumer education programs were the first developed and the best attended of all PCC activities. The major thing learned by the centers, other than how to gain attendance, is that classes must be designed specifically to meet the particular needs of the parents attending. Methods and content appropriate to high school home economics classes are not appropriate here, and most centers have evolved more effective ways of demonstrating homemaking skills to parents by trial and error.

PARENT ACTIVITIES DESIGNED TO STRENGTHEN SKILLS ESSENTIAL TO MAKING A LIVING, INCLUDING MAXIMUM OPPORTUNITIES FOR EMPLOYMENT IN THE PCC

Description

The Parent-Child Centers developed a variety of programs designed to strengthen the skills essential to making a living, the most prevalent of which was the employment of one or more members of the family in the PCC program. Seventy-seven percent of the PCC's employed at least one family member in the activities of the center; only eight centers did not employ any family members. Seven centers employed only one family member, but one center employed 22 family members. The three sites of the PCC on the Indian reservation employed a total of 15 family members.

As Table 18 shows, of the 146 family members employed, 97 were mothers, 16 were fathers and 33 were other family members.

The 16 fathers employed were drawn from a pool of 280 unemployed fathers in PCC homes.

TABLE 18

Parent-Child Centers Training and Employment of Family Members

Service or Activity	% Centers Reporting Service	Number of Family Members			
		Mothers	Fathers	Other Family Members	Total Served
Employment as PCC Staff	77	97	16	33	146
Training as Child Care Workers other than PCC Staff	17	81	0	0	81
Adult Basic Education, GED	34	199	74	0	273
Job Counseling	17	35	15	10	60
Vocational Rehabilitation	3	3	7	6	16
Typing	9	36	3	0	39
Driver Training	9	33	10	4	47
Auto Shop	3	0	5	0	5
Woodwork, Welding	20	12	42	0	54
Total		496	172	33	721

Included among the jobs provided PCC parents are some very traditional work roles, some developed in the early years of OEO-funded programs, and some new to the Parent-Child Centers. Many of the traditional jobs such as janitors, maintenance workers, cooks, or drivers are filled by parents. Nearly all of the 16 fathers are employed in this category. The roles of social work aide, teacher aide, and community outreach worker developed over the last five years in Head Start and other such programs account for most of the jobs held by mothers employed by PCC's.

Six of the PCC's have selected and trained some of the mothers to provide day care in their own homes for other PCC children. While this was a part of the plan proposed by many other PCC's, it proved very difficult to implement, especially in cities where licensing and code restrictions are very stringent and few PCC homes meet these requirements.

The only innovative role filled by PCC parents is that of Infant Educator. While the job is known by such various names as "Family Education Aide" or "Parent Educator," essentially this is the model developed by Dr. Ira Gordon in which the staff is trained to carry kits of materials to the homes of PCC families and demonstrate to the mothers ways of using the materials to stimulate their babies and young children. Several other innovative staff roles have been developed by the PCC's including the "Senior Friends" in one rural center and the "Alternate Home Mother" in another, but these positions are not filled by relatives of the children enrolled.

When parents, particularly mothers, are employed in PCC programs, the amount of contact with the family is maximized and the opportunity for impact for those families is vastly increased. As the following examples illustrate, contact with these staff-parents is really very great.

> --In one center "staff-mothers" participated in an extensive preservice and in-service training program. They now work full-time either in the nursery or in the outreach program while their children are in day care at the PCC.
>
> --In another, 12 mothers are employed to work in both the center and the home-visiting program. While day care is not provided for their children, other services are.

Almost without exception, field research associates have commented on the vast improvement in the mothers employed as staff during the course of the year. This quotation from one of the field staff illustrates the point made by many:

> There is no question in my mind that the PCC program has had a most benefical impact on the mothers employed. They are dressing better themselves and keeping their children clean and neat....Many of them are clearly enjoying improved self-concepts precisely because the program has helped them to be and to think of themselves as more capable and of more self-worth.

Another field associate commented that it was her observation that the mothers who were employed as staff first tried out newly learned concepts with their own children, and only if they found them useful or effective did they attempt to implement these techniques with other PCC children. In this way, the children whose parents are employed as staff are the recipients of far more intense and consistent intervention.

Meeting the criterion of employing parents as staff of the PCC's has provided both some of the greatest intervention opportunities as well as the most serious pitfalls. Training of indigenous staff with limited education and disorganized and deprived personal lives always presents difficulties. These problems are discussed elsewhere. When these staff members are also parents and fill the dual role of giver of service to other families and recipient of service from professional staff, the problems are multiplied. Reports have been that professional staff as well as the mothers find it difficult to relate as both clients and peers. When race is also an issue, the difficulties are further intensified. Maintaining confidentiality is a very difficult problem, particularly since the information that should be kept absolutely confidential is always that which makes the best gossip. Gossip between indigenous staff and the community has made problems in several centers.

Probably in recognition of the pitfalls involved in training and supervising as well as serving staff-parents, those programs in which the directors are social workers rarely employ parents. Of the eight programs which do not employ family members as staff, six have directors who are social workers; the total number of social workers employed as PCC directors is only seven. It is likely that the directors with social work training anticipated the role conflict involved in the dual position of staff and client and simply avoided the problems by not employing parents.

Training as Child Care Workers

Training for employment as child care workers other than for future staff in the PCC is being provided by six separate Parent-Child Centers to a total of 81 mothers.

In one center there is a well-developed training program for 19 mothers which meets five mornings a week to teach the mothers how to use toys, games, and equipment to stimulate infants. The mothers then visit other mothers to try out their new learning skills. While these mothers are in training, their children are cared for in the nursery. The mothers are paid $125 a month during the year's training. Since the program has been in operation only since September, it is too early to tell whether employment can be found at the end of this training period.

In three Parent-Child Centers mothers are trained to be day care mothers for the children of working mothers. In two midwestern centers the programs focus on early childhood development as well as child care. While some PCC mothers are providing day care for other PCC children, there is no record as yet of placement in jobs outside of the PCC.

Adult Basic Education

Though only a third of the PCC's reported programs in adult basic education, a total of 199 mothers and 74 fathers were attending such programs. In addition to the programs provided at the centers, it is possible that some PCC parents were referred to such programs sponsored by other agencies in the community.

The PCC's made a number of different arrangements for providing adult education, but most involved either the adult division of the public schools or a junior college.

> --In one community the junior college is providing PCC mothers and fathers with training toward the GED.
>
> --Four mothers in a rural center have completed requirements for high school diplomas and the PCC is trying to get a junior college to offer courses at the center.
>
> --At a southern PCC, indigenous staff and mothers attend classes sponsored by a junior college at the center.
>
> --In another, more than 20 mothers are working toward their high school certification or toward college credits.
>
> --In an urban PCC nearly half of the mothers enrolled at the PCC are continuing their education.

Other than recreational activities such as parties or potluck dinners, continuing education was the activity that involved the largest number of PCC fathers.

Job Counseling and Vocational Rehabilitation

Job counseling was reported to be provided by six PCC's and vocational rehabilitation services by a seventh. A total of 60 family members were reported to have received counseling, although no results of this counseling were reported. It is, of course, quite likely that other centers referred parents for job counseling to appropriate agencies. Such referrals would not be reflected in these figures.

Other Skill Training

A variety of other programs to develop skills among the parents include typing classes attended by a total of 36 mothers and three fathers, driver training for 33 mothers, ten fathers, and four other family members. Driver training was also provided for the staff of a number of rural centers so that the outreach program could be implemented.

In one rural area, a class in auto repair is attended by five fathers and woodworking and welding classes are provided by 20 percent of the PCC's and attended by 12 women and 42 men.

Summary

The most frequent program developed under this category is employment in the Parent-Child Center itself which was provided to 146 members of enrolled families including 97 mothers and 16 fathers. The fact that so few fathers were employed by the PCC's is to be expected. Only on the highest professional level, as in the role of pediatrician, is work with infants and toddlers seen as "man's work."

In addition to employment by the PCC itself, another 81 mothers were in training to become child care workers; hopefully at the end of training they will be placed in jobs outside of the PCC.

Thus, one out of eight families enrolled for service in the PCC had one member of the family employed or in training for employment by the PCC.

About one out of five families had an adult enrolled in some other type of skill training including completion of a high school diploma, typing, auto shop, woodworking, or vocational rehabilitation.

PROGRAMS DESIGNED TO STRENGTHEN THE SELF-CONFIDENCE AND SELF-IMAGE AS PARENTS, INTRAFAMILIAL RELATIONSHIPS, AND THE DEFINITION OF THE MALE ROLE WITHIN THE FAMILY

Although the Parent-Child Centers were also instructed to develop "parent activities designed to strengthen their self-confidence and self-image as parents and intrafamilial relationships between husband and wife (where both parents are present) and between parents and children" these can be regarded as outcomes of other programs rather than programs in and of themselves. Certainly one major purpose for providing parents with the opportunity to attend classes in child development or to observe their children in a group care situation is directed toward increasing parental feelings of adequacy and self-confidence in their role as parents. The relationship between a mother and father or between a mother and her children may well be improved by the refreshing experience of recreation away from the children, a class in typing, basic English or a charm course. This relationship may also be enhanced by employment, preparation for employment, by social services, counseling, or medical services. A mother without a toothache is apt to be a better wife and mother than one with a toothache. Thus, improvements in self-image and marital and familial relationships are program outcomes and are discussed at the end of this report.

Many Parent-Child Centers have pursued the criterion of establishing "activities to strengthen the definition of the male role within the family" by attempting to involve the fathers in the programs of the PCC's. While a few centers have made little or no attempt to involve the fathers or have made, as one field associate reported, "unimaginative, half-hearted, and futile" attempts to get active participation of the fathers, most have tried a wide variety of methods and programs to involve the fathers. Nonetheless, at year's end, almost every PCC had set as its second year goal "more active involvement of the fathers."

Meaningful involvement of fathers in PCC programs has been a challenge not readily yielding to solution for many reasons. First, nearly 42 percent of all PCC families are headed by women and there is no father, at least in the conventional sense of the term, living in the home. Second, and probably of great but usually unrecognized importance, is that the PCC fathers behave very much like other American fathers in that they do not see child care, particularly infant care, as part of their role prescription. Those activities that have been successful with PCC fathers are very much those which involve middle-class American men in PTA's, nursery schools, and other child-related institutions. While many activities have been pursued and abandoned, the ones that have managed to involve PCC fathers include:

> --programs to pursue formal education and employment when available. Unfortunately, only 16 PCC fathers have been employed by the PCC, and nearly all of these jobs are at the lowest levels, but few men want to work in an infants' program.
>
> --service on boards and committees where decisions are made on the development of programs and expending funds that affect their wives and children.
>
> --"men's work," which includes painting, carpentry, fixing up the PCC center, or making playground equipment for their children.
>
> --family socials, including picnics, field trips, and pot-luck dinners.
>
> --men's nights, card parties, pool, beer parties, or movies.

One center director has stated that he feels that the mother should be the prime contact, and that work with the fathers should be informal and indirect. It seems unreasonable to expect the PCC fathers to behave any differently from other fathers in America. To do so might not enhance the male role in the family at all.

Summary

Essentially these three criteria specified are goals or outcomes of other programs developed for parents within the PCC program, and are discussed more fully in Chapter XI. Efforts to involve fathers in the activities of the Parent-Child Centers have been successful to the extent that these efforts are in keeping with the activities in which other American men generally engage. PCC fathers have been involved in pursuing their own education or employment, board and committee work, fixing up the Parent-Child

Centers, and in social nights both with their wives and children and with other PCC fathers.

EXPERIMENTS IN PAYING MOTHERS TO PARTICIPATE IN THE PCC

While payments are made to parents in many Parent-Child Centers to work as staff or as job trainees through NYC or other stipends, there are only three programs that have established payments to mothers as incentives for them to attend the nursery or to participate in child development or home management classes.

Three different types of plans are operating:

> Center 1 makes a maximum payment of $1,200 per year, at the rate of $5.00 per half day attendance, up to five days a week. Mothers are paid to work in the nursery or the kitchen. As the field researcher reports, "the mothers are assigned to work by having their names posted on the bulletin board. This gives their participation in these activities the appearance of required labor rather than learning opportunities."
>
> Center 2 specifies $600 a year family allowance to be spent on field trips, equipment, and emergency needs. Three hundred dollars has been granted as emergency loans to families who can qualify. The mother works in the nursery or as an aide in the program to repay the loan. The money borrowed is not deducted from the welfare checks.
>
> Center 3 pays up to $400 a year at the rate of $8.00 per week for four hours' attendance. This money is not deducted from welfare.

In evaluating the plan of Center 1, the field researcher writes:

> The wisdom of paying the mothers a stipend is difficult to evaluate. Some of the mothers have looked upon it as a salary rather than a fee given just for learning. Those who continue to see it as a salary, in spite of its obvious gratuitous nature, have been known to complain about its smallness....Working in the nursery and kitchen the mothers feel that they are being poorly paid for doing the most undesirable tasks in the program. If no money were involved, perhaps they would see these tasks as part of their motherly responsibilities and a valuable personal contribution to the program.

The mothers attend approximately 50 percent of the time, and there has been about a 50 percent turnover in the 16 months of program operation. Many of the mothers have saved a considerable amount of money; this led to some difficulties with the welfare department, which finally agreed that the mothers could save up to $300 without jeopardizing their welfare benefits.

The plan at Center 2 is such that the parents must prove that they have an emergency need for the money before they are eligible, and it is then paid back by work in the PCC. There is the distinct possibility suggested that some of the parents may have created an economic emergency in order to qualify for later employment by the PCC. The children of these parents attend only about 20 to 30 percent of the time, so that the plan does not seem to have done much to encourage participation in other aspects of the program. Only 13 parents of the 40 presently enrolled have been in the program more than six months, so little can be said about the effect of the allowance plan in maintaining continuous enrollment. In general these parents have been selected from the "hard-core, multiproblem, multiagency" ranks and it may not be appropriate to compare their participation with the parents at the other two centers who are more upwardly mobile.

At Center 3 the mothers receive the smallest stipend--only a maximum of $8.00 a week. Few difficulties seem to have developed about this payment, possibly because it is smaller than at the other two centers, or possibly because it is clearly attached to attendance and participation in the play group in the nursery. The mothers at this center are not expected to work in the sense of cleaning up or fixing meals, but are expected to "work" with the children in the sense of participating in games, songs, reading, and so on. Of the 40 families who entered the program a year ago, only 21 are still enrolled. Those who have continued have an average attendance of about 65 percent, the largest attendance of the three centers paying stipends. About this aspect of the program, the field researcher writes:

> I also have some question about the payment of the mothers for attendance in the program. From studying the attendance patterns, it would seem that the mothers who are really interested would probably come regardless of whether they received payment or not, and the mothers who are not interested do not stay with the program, regardless of the payment.

The findings on these three methods of payment are in keeping with social psychological studies indicating that the greatest amount of attitude change is elicited by small payments of money, and that large payments of money are often interpreted as bribes and attitude change minimized. It would seem that Center 1 should clarify the difference between "participation in a learning experience" and chores, and if real work is expected, then an adequate salary for this work should be paid. The plan devised by Center 2 has the disadvantage of encouraging parents to have economic crises in order to qualify for a loan as well as to have the mother in a kind of indentured servitude. The third plan has produced greater attendance than found in most PCC's even though there has been a high rate of turnover among the families. It would seem that of the three plans, this one might be experimented with further to determine whether under different circumstances the mothers could be encouraged to attend over a longer period of time.

SUMMARY

During the first year of operations, centers learned ways of recruiting and gaining the attendance of parents in PCC activities, ways of holding their interest after attendance had been secured, and techniques to encourage staff to support parent activities.

The following were among the more successful ways of getting parents to attend programs.

--Personal invitation by a staff member or another parent produced better attendance than a posted notice, flyer, or mailed invitation.

--Parents were more apt to attend activities when babysitting services were provided.

--Refreshments, or the provision of a meal to adults as well as children, increased attendance.

--PCC parents, like parents everywhere, attended programs that they helped select and that they were interested in.

--Transportation to activities, while time-consuming for the staff, is essential for parents as well as children.

The more successful techniques used by the centers were those in which:

--the method of instruction was a demonstration or workshop rather than a didactic one.

--the instructor was sensitive to local conditions, individual life styles, and most of all, was accepted first by the indigenous staff as a "credible" instructor.

Three experiments in paying parents to motivate their participation were conducted. While the results are not directly comparable because they were conducted with very different groups of parents, certain recommendations can be made. Any money provided as an incentive to encourage participation should not be connected with work, nor should a family have to prove that it is destitute in order to qualify for the incentive payment. The experiment in which mothers were given a small amount of money for participation in the nursery program seems worthy of further study. While the results are not clear-cut because there was so much turnover in the enrollment, more frequent participation of the mothers was obtained in this program than in either of the other two experiments or in other PCC programs.

Among the activities most frequently participated in by the parents were child development classes, attended by about a third of the mothers enrolled and even by 51 fathers. Home economics and home management classes, mainly sewing, cooking, menu planning and nutrition, were attended by a large proportion of the mothers enrolled in the PCC's. These homemaking activities were attended by a total of 1,762 mothers.

Employment for 146 members of enrolled families was provided by the PCC. Ninety-seven of these were mothers and 16 were fathers. Another 81 mothers were engaged in training to become child care workers for eventual placement outside of the PCC. The mothers in work training usually received stipends either through NYC or the PCC itself.

While most of the parents involved in the programs are mothers, a significant number of fathers participated on boards and committees, attended educational programs, family night socials, card parties, or men's nights at the center, or worked at painting and fixing up the PCC's themselves. The PCC fathers have participated in ways very similar to those of American men of all social groups. It does not seem reasonable to expect otherwise.

RECOMMENDATIONS

1. The staff of the PCC's should be provided with training in methods and techniques shown to be effective in eliciting attitude and behavioral change in child-rearing methods. The trial and error methods often employed by the staff are costly in time and uneven in effectiveness.

2. The most successful programs for parents have been in the area of homemaking: sewing, cooking, nutrition, menu planning. These programs have been effective in getting the mothers involved, and have been well attended and received. They should be continued and expanded.

3. Child rearing, home management, and home economics are considered "woman's work" among all social classes and all cultural groups in the United States. It is unrealistic to expect men to attend or participate in these activities, and low-income men are

no exception. There is no reason for staff to continue to expend time and effort in pursuit of an unachievable goal.

4. The programs that have been successful in involving fathers should be expanded. These include adult education, job counseling, social activities such as smokers and game nights, and construction and rehabilitation of the centers.

5. There is a great deal of agreement among our field staff that the parents employed as staff of the PCC's were the group that benefited most. However, it must be recognized that in the first year at least, employment of parents as staff means that absenteeism is high, output is low, and the training and supervision needs are large. If these conditions are recognized and planned for, it is recommended that the employment of parents as staff be continued.

6. If parents are paid to participate in activities at the centers, the amount that they are paid should be a token one. The payment of an incentive allowance should be associated with attendance rather than work.

CHAPTER IX

HEALTH SERVICES

INTRODUCTION

No data have been more difficult to collect than that concerning the health services provided the children and the families enrolled in the Parent-Child Centers. Notwithstanding the difficulties involved in gathering the data, this chapter attempts to present as full a description as possible of (1) the in-center health education and preventive services, (2) the status of the health of the 1526 focal children on whom data were reported, and (3) the health services arranged outside the center and the types of services delivered. An analysis and assessment of the medical and health services are made within the limits of the data available.

To understand the kinds of health services provided by the Parent-Child Centers it is necessary to consider the communities in which these services developed, the resources available, and the attitudes of the poor and the PCC staff toward health care and toward the existing resources.

AVAILABILITY OF MEDICAL RESOURCES

The availability of medical resources within the communities served by the PCC's was a prime determinant of the type of service later developed. The problem of finding medical resources was greater in most rural areas than in urban ones. Not only are hospitals and institutions scarce, but physicians in private practice are overburdened. From one rural center the field associate wrote:

> ...there is such a shortage of doctors in this area that they only see sick patients. The doctors are reluctant to see any patients for preventive services, particularly poor patients.

From another rural area the field staff writes:

> Now that there is a growing awareness of medical needs, another problem has become more acute: shortage of medical personnel in the small towns. PCC can help, and has helped, to provide certain preventive and diagnostic services to a few low-income people among many in the Valley who need these and other services. But these are quite small contributions compared to the scale of the problem.

The nature of the problem in urban areas is different. Facilities are often overcrowded, have long waiting lists, and are physically inaccessible. In many of the 14 communities where the Parent-Child Centers were funded through the Neighborhood Services Program, health services were not activated in time for use by the PCC's. Most rural PCC's budgeted for medical services, but most urban ones coordinated the existing resources.

ATTITUDES OF THE POOR TOWARD THE UTILIZATION OF HEALTH SERVICES

Most PCC families and the indigenous staff employed to work with them share a "crisis-orientation" to health care. Poor people tend to recognize the need for medical intervention only when a physical crisis or some overt illness occurs. Preventive or future-oriented medical care is often outside the realm of health expectation of the poor. The pressing need of the poor to be concerned with the present--getting enough to eat, keeping the children in shoes, keeping the family together--leads low-income families to emphasize those medical services for which there is an immediate, tangible need.

In addition, the poor and the indigenous staff often share a history of frustrating experiences in attempting to obtain services from existing public facilities. Long experience with overcrowded facilities and with two- and three-hour waits have led many PCC staff and families to view all medical services with great suspicion.

As a number of PCC's have discovered, it is not enough merely to make medical services available to families. Many have a fear of doctors that keeps them from utilizing services. The director of one rural center reports that when staff can finally get a mother to visit the doctor, they feel that she has been "reached." This director says that the mothers are often afraid to go to the doctor lest some "dread disease" be uncovered. Such a fear is quite common and together with the widespread superstition and ignorance about medical practices, there results the reluctance of many poor people to visit the doctor even when appointments are made.

On the other hand, when poor families do seek medical services, their experiences are so often frustrating that existing negative attitudes are reinforced. Long waits in clinics, brusque staff, and fragmented services all combine to make the poor reluctant to return for needed services.

IN-CENTER HEALTH SERVICES

The Role of the Nurse in Health Services

While most medical services are arranged for outside of the Parent-Child Centers, those provided within the center are also of great importance. Most of these in-center activities are developed and coordinated by the 27 registered and licensed vocational nurses employed by 20 PCC's. These nurses, together with the 11 nurse's aides and two doctors employed part-time by two different PCC's, comprise the staff of the PCC health programs. Of the ten centers that did not employ a nurse or a nurse's aide, nine are located in urban areas. Even though nurses are more difficult to recruit in rural areas, only one PCC did not employ a nurse on its staff. The families at this one PCC had received all their health services from the U.S. Public Health Service prior to the PCC, and continue to do so.

Because the reporting of health services from many of the PCC's has been fragmentary, it is difficult to separate the impact of the nurse on the delivery of outside health services from the reporting of these services. The effect of the nurse on the reporting of services is clear. In those centers where a nurse is employed, Health Status Reports were returned for 54 percent of all the children ever enrolled. In those centers where no nurse is employed, these data forms were returned for less than 20 percent of the children. We cannot, of course, be sure that greater reporting also means greater service, but this does appear to be the case. It is the consensus of our field staff that the presence of a full-time nurse in a Parent-Child Center is a crucial factor affecting the quality of the health service program provided to the families.

Nurses within the Parent-Child Centers provide five major areas of service:

1. alerting and training other PCC staff about the health needs of families as well as how to spot symptoms,
2. developing and coordinating outside referrals for examination and treatment of children and families,
3. interpreting the need for these referrals to families and interpreting the instructions of the doctors to the families once the visits have been made,
4. examining children before they are admitted to the nursery, and
5. developing in-center health and nutrition education programs.

Regardless of the adequacy of resources existing outside of the PCC, attention of the staff must be focused on health needs if these services are to be utilized by the families on any but a crisis basis. From one center after another the field associates report that the initial attention of nonprofessional staff to health is minimal and that the nurse is crucial in training other staff persons to recognize the importance of preventive approaches to health. An example of such a report was made by one of the field research associates:

> The value of a nurse in an urban PCC is readily apparent in this center. To most PCC staff, health, except at a lip service level, has a low priority until parents or child are overtly and seriously ill. This program is fortunate to have a motivated young woman as nurse. She keeps the staff conscious of health needs and gets families to service when they need it. She would benefit greatly from training and supervision in how to teach preventive measures and in the integration of nutrition and preventive care in the total PCC program.

The nurse plays a central role in developing and coordinating external arrangements for medical services. Although arrangements for service may be made with a university clinic, private physicians, or a community health agency, the problem of getting families to keep appointments exists and the nurse is often a key person in effecting the connection. This is a three-fold task: a resource appropriate to the need must be located, an appointment must be made, and the family must be encouraged to keep the appointment. One FRA describes the situation clearly:

> Since the PCC hired a nurse there is better liaison with community resources. The nurse complains that the doctors make no effort really to communicate with the parents and that she must fill that role. She also keeps a running record on the children, their shots, etc....The nurse is young, energetic, and well responded to by the parents. She makes the clinic appointments, sees that they are kept, and carries out other health activities....

On the other hand, one PCC housed within the Neighborhood Health Center which does not have a nurse, gives quite another picture:

> The adjoining health clinic is supposed to provide services, but with the exception of the Teenage Parent Coordinator, the staff more or less assumes parents seek and use these services when needed. The net effect is that they pretty much ignore health.

As a result of this lack of attention by the staff, only about ten percent of the children enrolled at this center have been examined. There is ample evidence from this and other PCC's that the mere provision of health services is not enough. The staff must emphasize medical care energetically if these services are to be utilized by the hard-core poor families enrolled in many of the centers.

Where nurses are employed, they usually examine the children as they come to the center to participate in an infant or toddler play group. Though all PCC's with center-based programs were supposed to employ a nurse, several have not adhered to this condition of their grant. Field associates have reported seeing children in the nurseries with colds, conjunctivitis, and other contagious illnesses when no nurse was there to screen them. Since very young children are so susceptible to infections, screening can be vital to the health of the children. In regard to this aspect of her job, one PCC nurse writes:

> When the children arrive in the morning, I examine them for colds or other signs of infections. They then have their juice and crackers and we go together to brush teeth.... During the day I am on hand to talk to mothers about medical appointments, and to take care of any cuts, bruises, or "owies" that develop.

In-Center Health Education Programs

The health education classes and individual conferences provided or coordinated by the nurses constitute a major portion of the in-center health programs. Through these, the PCC's can make some of their most valuable contributions through the improvement of family attitudes and practices concerning personal cleanliness, nutrition, family planning and the seeking of medical care.

Services to PCC families were reported in four major areas: (1) dental and health education, (2) planned parenthood, (3) Red Cross and safety, and (4) prenatal classes. Because reported activities tend to reflect structured group situations, the data probably include only a small percentage of those individuals actually served. Many of the services occurred in informal, staff-client contacts and are not reflected in the data reported by the centers. One nurse commented not only on this type of informal contact, but on her assessment of such contacts:

> I believe many times more is accomplished in some of the discussions held briefly and unplanned in the homes and centers than in some I have prepared and worked over for hours. To be able to answer questions when they come up is better than formal, lengthy discussion at a later date.

Twenty-six percent of the centers reported structured health education activities involving 136 mothers and 15 fathers. Nine percent of centers reported dental health activities including 65 mothers. Most of these classes were conducted by the center nurse or nurse's aide, but at one center the University Affiliate arranged for professional consultation. At another center, a doctor on the Policy Advisory Committee meets frequently with parents to provide health education talks. With mothers mostly in attendance, these classes cover topics ranging from personal hygiene to cold prevention to toilet training techniques for children.

Dental health classes include formal classes by a hygienist as well as instruction by the nurse on how to brush teeth and diet for oral hygiene.

Family-planning classes and lectures have been reported to include 124 mothers, seven fathers, and 15 other family members. These are in-center classes and do not include those individuals referred to family-planning clinics or private physicians for information, pills or devices. The field observer at one center reports:

> Several mothers have received planned parenthood education, and some are reported to be using intrauterine devices. According to the project director, this has had a beneficial effect on these mothers and actually improved the wife-husband relationship in some cases.

Red Cross classes were reported by six percent of centers for a total of 12 mothers. Another six percent of centers reported safety instruction to a total of 54 mothers. One center provided this Red Cross instruction for all the staff as part of the in-service training program.

Prenatal classes were reported by four different centers for groups of teen-age expectant mothers. These classes ranged from one center that has regular weekly luncheon meetings for the girls, to one that has classes four hours each morning, five days a week. Proper diet, hygiene, and care are discussed, and trips to hospital facilities are made, as are referrals for prenatal care.

In-Center Nutrition Programs

Three types of in-center nutrition programs have been developed. (1) Those programs that teach nutrition, menu-planning, and budgeting to mothers are discussed in the chapter on programs and activities for parents. (2) A second type of program involves the actual provision of food within the PCC. (3) One center has developed an intensive study on the nutritional status of 17 children enrolled in the PCC.

Snacks are provided by all but two of the Parent-Child Centers that are serving families, and 16 centers provide one or more meals a day for those children attending day-care or play group sessions at the center. At some centers this is a light lunch consisting of a sandwich and milk, but most of the PCC's that serve lunch take the opportunity to provide a full meal at noon-time. One PCC serves over 1000 meals a week to the children and mothers who attend day-care and parent education programs at the center.

A nutrition study completed by one of the centers on 17 children indicated that 14 of the children had an 82 percent deficiency in iron, that eight children had a 47 percent deficiency in both calcium and vitamin A, and that others were deficient in vitamin C, riboflavin, and niacin. These findings led to a special nutrition program described by the health coordinator of that center:

> As a result of these statistics, it was decided to provide breakfast at the center each morning. We have noticed a remarkable change in many of our children in the three weeks since this was initiated. The infants have been more cheerful, and seem to respond better to all activities. The teachers have noticed a longer attention span and better cooperation in the older children. In addition

> to breakfast, we have continued to serve a light snack in mid-morning. In spot checking the daily records, we have noticed a weight gain in many children in the past several weeks. We plan to do a comparison in weights after two months of serving breakfast with the previous two months when breakfasts were not served.

THE MEDICAL SERVICES PROVIDED

All but two of the Parent-Child Centers serving families developed a variety of external arrangements to provide for the medical needs of the children enrolled and to coordinate health-related resources for other family members. Of the other two, one was already in a situation that provides comprehensive services for all family members, and the other had not yet implemented these services.

In the following section, we first describe the reports of the health examinations of the children under three, then of the services provided for these focal children. To the extent that the data permit, we describe the services to other family members, and finally describe the major types of arrangements made by the centers for the delivery of service. On the basis of this analysis, some tentative recommendations about the provision of medical services in future programs are made.

Medical Examinations

The Parent-Child Centers report that a total of 3494 people, or about 25 percent of all those that have ever been enrolled, have been provided with medical examinations as indicated on Table 19. Of the 3449 focal children enrolled since the inception of the program, health examinations have been reported on 1526, or about 44 percent. For the focal children, Health Status Reports were completed by staff at the center and the examining physician and returned to the contractor for processing.

During the course of the study an instrument was developed and revised to attempt to gather information about the health status of the focal children. Its first form was an adaptation of the instrument used in the national study of the health status of Head Start children. It was then revised following the suggestions of the OEO project manager. A copy of the Health Status Report and the tabulated information are shown in Appendix C. This instrument suffers from the attempt to gather two kinds of information at the same time: information on the health status of the children at the time of intake to the PCC, as well as information on the services provided by the PCC. Since the data forms are completed at the time of the initial examination by the PCC physician, it does not yield much information on the kinds of services provided.

TABLE 19

Number of Medical Examinations Reported
(By Source and Recipient of Service)

	Private	Group	NSP	Total
Pregnant Women	189	89	70	348
Focal Children	733	408	313	1526
Other Children	598	75	77	750
Other Family Members	407	166	297	870
Total Examinations Reported	1927	810	757	3494
Percent of Family Members' Examinations Reported	34	20	19	25

Height and Weight

According to the reports of the mothers, only five percent of the PCC babies weighed less than five pounds at birth and 23 percent weighed over eight pounds. It is possible that the babies grew slightly heavier in the recollections of the mothers, but they appear to be within the normal range at birth. The same is found of the height and weight of the children at the time of examination. In fact, as shown on Graphs 3 and 4, the PCC children tend to fall in the upper range of national norms for weight, but in the lower range for height.[1] Taken as a group, these are short, heavy children although of course the range is great. This would seem to be consistent with the general dietary patterns of low-income families where starchy foods account for a large portion of the daily diet. Given the distortions of any height-weight tables that reflect means, and the large amount of individual differences, all that can be said about the PCC children is that they appear to fall within the normal range for height and weight.

Because measures of height and weight are considered by many physicians as important indicators of general health status, we attempted to compare these growth indicators at various points in the program. Accordingly, each center was sent a roster of all the children for whom height and weight measures at intake had been received. This roster, sent in the fall of 1969, asked that each child be weighed and measured again.

In response to this request, 413 weights and a smaller number of height measurements were received. All children who received less than nine months or more than twelve months of service were eliminated from consideration and also all those who had entered the program later than their twenty-seventh month, so as to have

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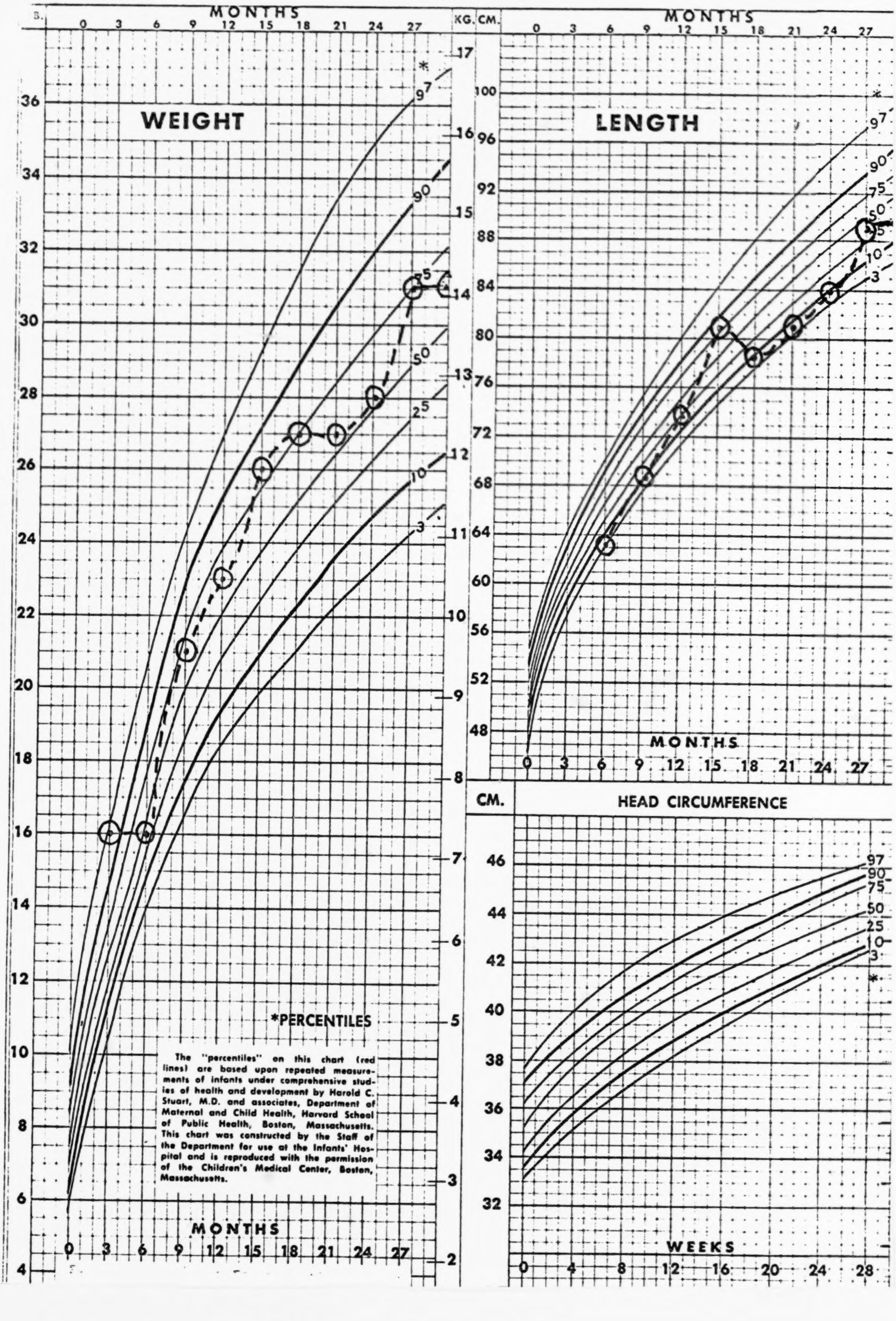
[1] See Appendix C for detailed height and weight information.

INFANT BOYS

GRAPH 3:

BIRTH DATE

THE CHILDREN'S MEDICAL CENTER, BOSTON - ANTHROPOMETRIC CHART

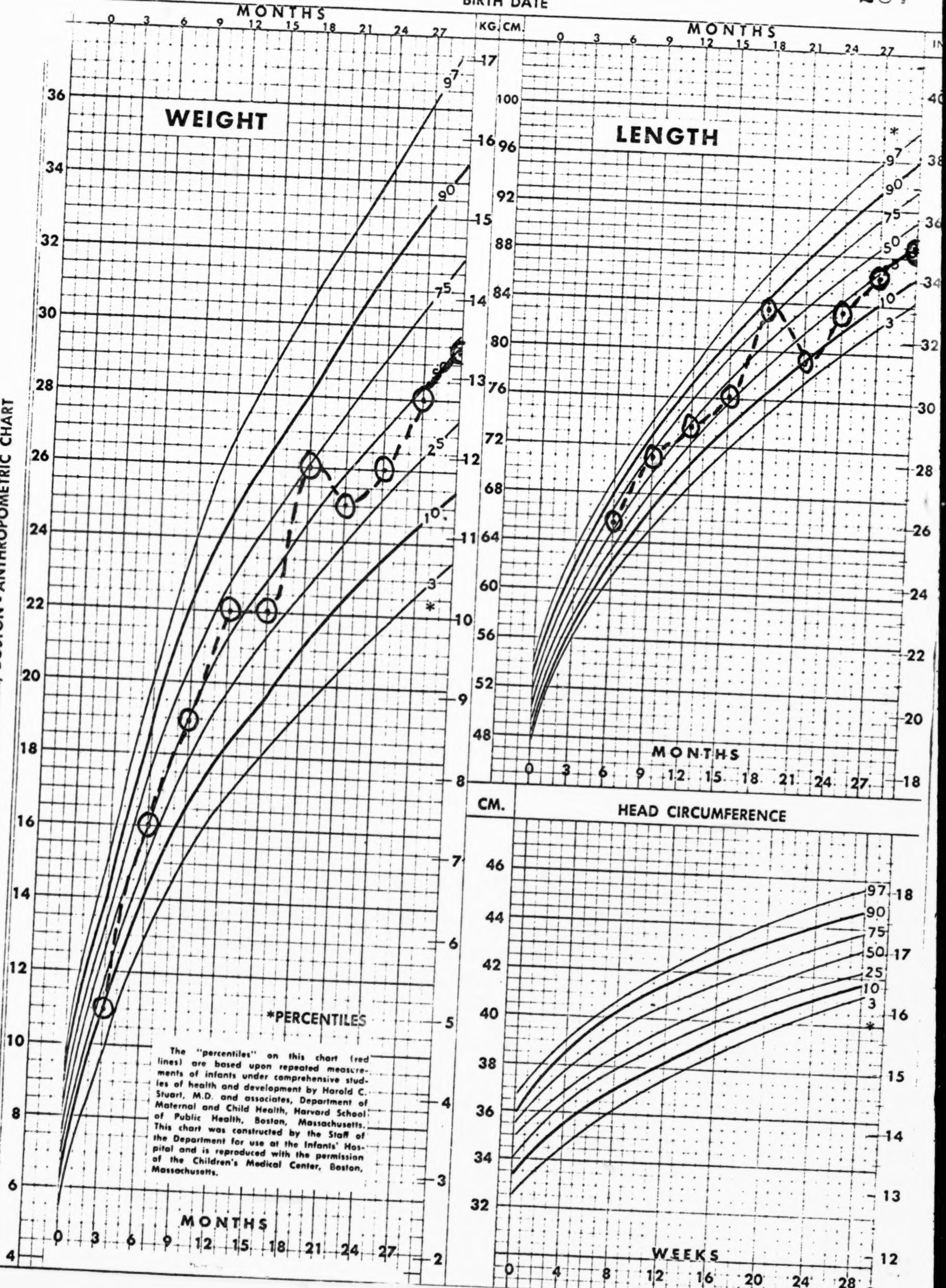


***PERCENTILES**

The "percentiles" on this chart (red lines) are based upon repeated measurements of infants under comprehensive studies of health and development by Harold C. Stuart, M.D. and associates, Department of Maternal and Child Health, Harvard School of Public Health, Boston, Massachusetts. This chart was constructed by the Staff of the Department for use at the Infants' Hospital and is reproduced with the permission of the Children's Medical Center, Boston, Massachusetts.

GRAPH 4:

INFANT GIRLS



The "percentiles" on this chart (red lines) are based upon repeated measurements of infants under comprehensive studies of health and development by Harold C. Stuart, M.D. and associates, Department of Maternal and Child Health, Harvard School of Public Health, Boston, Massachusetts. This chart was constructed by the Staff of the Department for use at the Infants' Hospital and is reproduced with the permission of the Children's Medical Center, Boston, Massachusetts.

a body of data on children who had entered the program early enough to have received at least nine months of service--a period considered minimal for a meaningful measurement of change in weight.

Of the 413 responses, only 46 met these criteria. Mean weight changes were computed for nine age groups, and compared with changes that could be expected in normal children, as derived from a standard infant weight chart. These data are presented as Table 20.

It appears that, on the whole, these 46 children gained weight at a normal rate. Boys tended to gain weight more rapidly between 10 and 15 months than was expected, and girls consistently gained less weight than was expected.

Previous Care by a Physician

This question was asked in the attempt to find out whether the PCC children had been receiving medical services prior to the PCC or whether these services came as a result of the PCC. However, since there was no response to this question on 68 percent of the data forms, it is difficult to find any meaning in the responses. Twenty-five percent reported that the children had been seen within the last year by a doctor, two percent within one to two years, and two percent reported that the child had not been seen by a physician since birth. However, since birth was within the last year for more than 30 percent of the children, response could not be interpreted.

Immunizations Prior to PCC Program

Somewhat more than half of the children enrolled in the PCC programs had been partially or fully immunized for polio and DPT prior to PCC enrollment. That between 22 and 24 percent had not received even partial immunization must be considered in the light of the fact that 17 percent were under five months of age at the time of intake. Only 23 percent were reported to have received a smallpox vaccination prior to the PCC and 26 percent a vaccine for measles.

TABLE 20

Actual and Expected Weight Increases of Children Enrolled 9-12 Months

Age at Intake	BOYS			GIRLS		
	Actual	Expected	Difference	Actual	Expected	Difference
(mos.)						
0-3	11.7	10.25	+1.5	9.0	12.0	-3.0
4-6	9.0	9.0	0	5.7	8.25	-2.5
7-9	5.0	6.25	-1.25	5.7	6.75	-2.0
10-12	9.0	5.0	+4.0	5.0	5.5	- .5
13-15	7.8	4.75	+3.05	5.3	4.75	+ .5
16-18	4.0	4.5	- .5	4.0	4.75	- .75
19-21	4.8	4.0	+ .4	2.5	4.0	-1.5
22-24	5.3	5.75	- .45	4.7	6.75	-2.0
25-27	6.0	6.75	- .75	4.2	7.0	-2.8
Means	7.0	6.25	.67	5.1	6.6	-1.6

N=46

Expectancy based on Tables of Children's Medical Center, Boston, Massachusettes.

Screening Tests Done at the Time of Examination

That relatively few screening tests were done when the Health Status Reports were completed should not be taken to mean that screening tests were not done at a later date. There is frequently good reason not to do screening tests at the time of an initial pediatric examination. Rather than terrorize a child by a variety of blood tests, shots, and other screening procedures, many physicians will wait until some future examination. It must be recalled that all the information on this form was completed at the time of the initial examination. In 69 percent of the cases, the tuberculin screening test was either not done or was not reported. When it was done, 28 percent of the children showed a negative response. Although the medical information tabulation reports zero percent of positive responses, 15 children were found to have a positive tuberculin response. The number was not large enough to amount to one percent.

No test for anemia was reported for 53 percent of the children, including the 37 percent who did not answer and the 16 percent who responded that no test was done. Though the overall percent of children with anemia reported is 12 percent, in centers where more than half of the children were examined, 20 percent were found to be anemic. This figure corresponds closely with other studies which indicate that about 24 percent of low-income children are anemic in the preschool years.

It is obvious that many of the examining physicians rely on clinical observation to determine the presence of anemia among the PCC children. The limits of such observation are described in a report on malnutrition by Delbert Dayton:

> Although clinical signs of malnutrition have been used to assess nutritional status, it has been found in Guatemala that these signs do not occur in the preschool child with sufficient frequency to be of great value.[1]

---

[1] Delbert H. Dayton, "Early Malnutrition and Human Development," Children, vol. 16, no. 6, (November 1969), p. 216.

The prevalence of iron-deficiency anemia was again confirmed in the study of nutritional intake done in one of the PCC's. This study, previously discussed in the section on nutritional programs, indicated that of the 17 children whose diets were studied, 14 were suffering significant iron deficiency.

In the light of recent findings about the effects of iron-deficiency anemia on growth and development, and particularly on intellectual development, screening tests for anemia would seem to be indicated for all children. Where the present medical arrangements of centers do not provide for such tests, other arrangements for them seem to be indicated.

Illnesses and Treatment of Children

Illnesses and medical conditions diagnosed were categorized on the intake examinations. The most frequent conditions reported were skin diseases including impetigo and eczema, chronic respiratory diseases, infections including otitis media, and umbilical hernias as shown on Table 21. As shown also, more than half of these were discovered in the PCC itself.

TABLE 21

Medical Conditions Diagnosed in Focal Children

	Total Reported	Previously Known	Found in PCC
Behavior or learning difficulty or retardation	34	7	27
Neurological disorder, epilepsy, cerebral palsy	19	11	8
Skin disease, impetigo, eczema lesions	107	50	57

TABLE 21 (Continued)

	Total Reported	Previously Known	Found in PCC
Chronic respiratory diseases (including allergies)	74	45	29
Acute infections, including otitis media	59	13	46
Heart murmur, consultation needed	21	4	17
Definite heart disease	8	3	5
Umbilical hernia	56	21	35
Inguinal, femoral or other hernia	5	2	3
Tonsil or adenoid disease	38	12	26
Urinary tract disease	14	8	6
Phimosis (circumcision recommended)	28	5	23
Orthopedic disability or defect	35	15	20
Evidence of severe punishment, battered child	0	0	0
Evidence of malnutrition or nutritive deficiency	26	7	19
Chronic diarrhea or vomiting	13	10	3
Endocrine imbalance disorder	2	1	1
Aural tract or apparent auditory disorder	8	3	5
Visual defect or disability	7	2	5
Abnormal dental development, dental disease or problems in dentition	8	4	4
Other anomalies or defects	15	4	11
Other diseases, disabilities	52	17	35
Total	629	244	385

Tables indicating the presence and degree of severity of illnesses and medical conditions and the treatment plan are shown in Appendix C. Most conditions reported were to be treated by the examining physician. Those conditions defined as acute were the most likely to be treated by the examining physician; these included acute infections and malnutrition. Interestingly enough, very little previous treatment was indicated for chronic cases. Only five percent of chronic respiratory cases had received prior treatment, and only six percent of behavior-learning problems and 12 percent of the cases of definite heart disease had received previous treatment.

The most likely conditions referred elsewhere for treatment were orthopedic and skin conditions, behavior and neurological disorders, heart murmurs, and umbilical hernias. Only a total of 18 illnesses were reported for which no treatment resource could be found. Thus it can be assumed that the PCC medical resources were either able to treat or arrange referrals for virtually all of the illnesses discovered among the children examined.

Of the 1526 children examined, only 53 percent, or 814, did not have any illness or condition at the time of examination, as shown in Table 22.

Information about follow-up treatment for children under the age of three was to have been reported on a data gathering instrument called the "Medical Contact Record." Had this form been completed by staff of the PCC's on all children taken for medical services, there would have been a record of the quantity of service provided and of the kinds of service most often needed and received by the focal children. Unfortunately, this task proved very difficult if not impossible for many of the centers, particularly those where the families made their own medical arrangements at NSP clinics or BIA health centers, or where appointments were not arranged through

TABLE 22

Number of Medical Conditions of Focal Children

Number of Illnesses or Conditions	Number of Children	Percent of Children
None	814	53
One	319	21
Two	90	6
Three	38	3
Four	17	1
More than Four	13	1
Did Not Answer	235	15
Totals	1526	100%

the PCC itself. Reports were received primarily from those Parent-Child Centers utilizing private physicians, probably because most of these appointments were made and paid for by the PCC and records were kept by the center nurse or data coordinator. Thus, Medical Contact forms were returned by a total of 18 Parent-Child Centers, or about 46 percent of those serving children. A total of 84 forms were returned, representing a sample of about 20 percent of the months of service provided to families. In all likelihood this is not a representative sample of the kinds of services provided by centers as a whole, but it is the only quantitative information that was reported.

A total of 1295 referrals were reported to treatment services after the initial examination. As Table 23 indicates, referrals for respiratory conditions are by far the most frequent, followed by requests for diagnostic tests, and treatment for acute infections, including contagious diseases, and for intestinal symptoms.

TABLE 23

Referrals for Health Services
(Children Under Three)
(Based on 84 Monthly Reports From 18 PCC's)

Illness or Condition	Number of Children
Behavior and Learning Problems	21
Neurological Problems	9
Heart Conditions	13
Vascular Conditions	1
Urinary Tract	9
Orthopedic Conditions	18
Acute Infections and Contagious Diseases	79
Respiratory Conditions	388
Skin Diseases	75
Parasites	26
Intestinal Symptoms, Diarrhea	74
Abdominal Conditions	3
Nutritional Disturbances	58
Accidents and First Aid	76
Diagnostic Tests, Blood Counts	180
Other Medical Conditions	180
Dental	85
Total	1295

Though most of the referrals for treatment are for acute infections, cuts, bruises and skin infections, a number of serious conditions were also treated including 14 cases of pneumonia and severe otitis media. A total of 26 children were reported to have been referred for parasites, but a number of PCC's instituted mass programs within the center to eradicate parasites, a prevalent condition in many areas of the country. One such program is described by a PCC nurse:

> In July, one of our children was hospitalized in critical condition due to severe Ascariasis, despite the fact that her stool showed no ova or parasites present. We inquired about this curious problem, and found that negative readings were often falsely negative due to the worm's irregular habits. As a result, we initiated a mass program to administer the Ascaricide Mintezol to all participating children as a preventative measure. As of today, only six children have not been reached due to their absence from the center.

In spite of the difficulties involved in getting quantitative data, the real contribution of the health programs to families cannot be overlooked. Our field observers report innumerable cases where the health services of the PCC were either a matter of life and death or meant the difference between a warped and deformed life and a decent one.

> One of the toddlers swallowed a bobbin, and but for the fact that the PCC health aide rushed to her house and drove her to the hospital, she might well have suffocated.
>
> Several of the mothers in this center had surgery provided, which if the conditions had gone untreated, might well have cost them their lives.
>
> One of the children pulled over a pot of boiling water from the stove at home, and had second degree burns over much of her body. The PCC arranged for her to be admitted to the burn unit at the medical school.
>
> One of the babies born to a teen-age mother was found to be addicted to heroin at birth. Without the immediate services provided at the university hospital, this child might not have survived.

> A year ago when I first saw this little boy, his legs were so deformed he walked on the outside of his ankles. The PCC arranged for him to get leg braces and corrective shoes. On this trip I saw him running with the other children, braces and all.

Health Services for Other Family Members

Examination and treatment services were arranged for all family members by about 20 of the Parent-Child Centers. These centers reported the following number of examinations:

Pregnant Women	348
Siblings of Focal Children	750
Other Family Members	870

It is quite doubtful that the number of examinations reported actually reflects anything like the total number arranged or coordinated, since much service was provided without the knowledge of the PCC, particularly in the urban areas.

Dental Services for All Family Members

The dental needs of most of the focal children are quite limited until they begin to approach three years of age, but the dental needs of their siblings and other family members are often great. Many of the PCC's did not allocate funds to provide for adult dental needs. Those that did were able to provide more service than those centers that hoped to utilize existing public resources which were already overcrowded and understaffed.

So many of the adults in the PCC's had gone without dental care most of their lives that when professional care was arranged, it was necessary to extract most if not all the teeth of even very young parents. One rural PCC arranged for extractions and dentures for twelve of the mothers enrolled. This PCC also arranged for the repair of a harelip of one of the mothers who was then able to speak clearly for the first time in her life.

One urban PCC contracted with a private group of dentists for service to the staff and families of the PCC. During the first three months of operations these families made 447 appointments for prophylactic treatments, fillings, extractions, and dentures. This group is providing the most comprehensive dental services of any within the PCC. Given the scarcity of public dental services in most communities, it is probably not feasible to expect to be able to utilize existing resources without some allocation of funds for this need.

Summary

On the whole, these data are not inconsistent with other epidemiological studies of poor infants. This sample reflects in its height, weight, and high incidence of anemia the consequences of the high starch, low protein, vitamin and mineral deficient diets so often found in low-income families.

The incidence of diagnosed illness and disability--both chronic and acute--is clearly higher than that seen among the population of children as a whole. Since the health status data reported represent less than half of the population of PCC children, we cannot be sure of the extent to which they are representative of PCC children as a whole. Reports from those centers which provide data on all or nearly all of the children do not present a lower incidence of disability. Field observers for the most part have described many of the children with terms such as "wan," "pale," or "lethargic and unresponsive." A few have commented that the children look healthy and energetic, but these reports are in the minority. Although no system for reporting the deaths of children was implemented fully, reports of the death of ten of the PCC children were received. Of these, three were crib deaths, three from accidents and the others as a result of illnesses.

The health status of the focal children enrolled would indicate that these children can be expected to require more health care than the general population of children their age.

There is wide variation between centers in the amount of attention paid to the health needs of the families as well as in the quantity and quality of services provided. Nonetheless, our field research associates were in near unanimous agreement that the health education, nutrition, and medical services were the ones showing the greatest results.

PATTERNS OF PROVISION OF HEALTH SERVICES - EXTERNAL ARRANGEMENTS

Although most PCC's utilized a wide variety of sources to meet the major health needs of the families, three major sources were utilized: (1) private practitioners, (2) public sources, including university clinics, public health departments and group plans, and (3) neighborhood health centers. It has been difficult to classify the sources of health services because almost every PCC supplemented their primary source with a variety of other facilities and services. For example, many of the centers that utilized private community physicians for most services also utilized the local health department for various preventive services such as immunizations. Centers that bought group insurance for families also used private dentists and physicians for some services. Most centers designated as NSP utilize health center clinics, some private medical sources and some university facilities.

1. Medical Services from Private Sources

Twelve centers reported that the primary source of their health services was private practitioners as shown in Table 24. The most common pattern reported was for the PCC to pay for visits to individual doctors or dentists either directly or through an insurance policy, such as Blue Cross/Blue Shield, but seven centers depended (in whole or part) upon the donation of professional services.

TABLE 24

Pattern of Provision for Health Services
(Private Sources - 12 Centers)

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--Private physicians Dental--Private dental group	PCC insurance policy (private)	14 pregnant mothers 181 siblings 68 other family		74 83%	1 R.N. 3 L.P.N.	Cancer detection--95 PAP smears. Cooperation from State Health Dept. for in-service training.
Medical--Private physicians	PCC insurance policy (private)	12 pregnant mothers 71 siblings 42 other family	86	30 50%	R.N.	So few doctors in area that it is difficult to get appointments for examinations for preventive care.
Medical--Private clinics, private physicians	PCC comprehensive state insurance policy			65 58%	R.N.	Generally good resources exist; no mention of dental facilities. Greatest problem is follow through.

TABLE 24 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--Private physicians Dental--Public health dept.	Donate professional time			40 38%		Doctor on PAC helped find medical resources. Center has had difficulty finding enough donations of professional time.
Medical--Private physicians	PCC donated professional time	34 pregnant mothers 51 siblings 50 other family	2	53 50%	R.N.	Lack of available medical resources, 25% of children under 36 months had cavities.
Medical--Private physician USPHS Dental--Private dentists	PCC Blue Cross insurance policy	49 Medical 36 Family Dental*	421	65 92%	2 Aides	This center has provided very comprehensive medical services from many sources to all family members.
Medical--Private physicians Dental--Private dentists	PCC Blue Cross/ Blue Shield Ins. PCC Dental Ins.	62 siblings 106 other family		30 33%	R.N.	Due to influence of PCC a new health program for poor started in region.

* From FRA reports.

TABLE 24 (Continued): Pattern of Provision for Health Services

Service Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--Private physicians Dental--Private dentists	PCC PCC	1 pregnant mother 22 siblings 18 other family	137	36 86%		Parents enrolled in PCC in order to qualify for medical services. Subcontracted to neighborhood organization.
Medical--Private physicians	PCC	13 pregnant mothers 1 sibling 7 other family	53	105 51%	R.N.	Resources are scarce and area covered by PCC large.
Medical--Private Dental--Private	PCC Donated professional time	8 pregnant mothers 24 siblings 37 other family	419	82 74%	1 R.N. 2 L.P.N. 1 Aide	M.D. on Policy Advisory Committee. Has mobilized medical resources for PCC and organized a committee of the Medical Association to recruit more doctors to area.
Medical--Private physicians Dental--Private dentists	PCC	18 pregnant mothers 54 siblings	3	89 39%	R.N. + Aide	106 immunizations

TABLE 24 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--Private physicians Dental--Public health dept.	PCC Blue Cross/ Blue Shield policy	40 pregnant mothers 132 siblings 41 other family	261	64 99%	1 R.N. + 3 Aides	Referrals Reported by Director: Well Baby Clinic--152 Eye Clinic--4 Crippled Children's Hospital--4 Family Planning--17 Immunizations--44 Dental--39 Speech Therapy--38 Physical Exams--79 Medical Ref.--79 Dental Exams--39 Dental Ref.--39 Special Exams--5 Hospitalization--17 Medication--230

Eight of the 12 PCC's which provided services through private practitioners were located in rural areas. Lack of public medical facilities such as universities or health clinics obviously made this the only feasible program. Most of these rural areas also suffered from a shortage of medical personnel of all kinds. One rural center in part relieved this shortage by arranging for a mobile health unit to provide examinations for all the PCC children as well as most of their parents.

2. University Clinics, Public Health and Group Plan Sources

Twelve centers reported that public or group plan facilities were the primary source of services as shown on Table 25. This category includes the local health departments, university and hospital clinics and two centers where health services are provided by Kaiser Permanente branches.

3. Neighborhood Services Program-Affiliated Centers

While a total of 14 Parent-Child Centers were designated to be funded through the NSP's, only 13 of these centers have been funded to date. One of the NSP centers decided to provide PCC families with prepaid insurance and to compare the satisfaction of the PCC parents with this type of health service to those of the NSP, thus reducing the number of PCC's in this category to 12. As originally conceived, the NSP affiliated centers were to tie in to the medical and dental services coordinated or provided by these neighborhood organizations. As things turned out, however, many of these NSP programs did not get organized in time to provide services for the PCC's. Thus a number of NSP-affiliated centers made other arrangements for the provision of services, as shown in Table 26.

Although there were only 35 funded centers, the three tables show a total of 36 medical plans. One rural PCC which had two

TABLE 25

Pattern of Provision for Health Services
(University Clinics, Public Health,
and Group Plan Sources - 12 Centers)

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--University clinics Dental--Public health dept.	Donated time PCC; Health dept.	20 pregnant mothers	3	60 50%	R.N.	X-rays, PAP smears, blood tests, family planning
Medical--Public health dept. Dental--Public health dept.	BIA BIA			48 62%		Medical forms completed by center director, children not examined. Health care provided prior to PCC
Medical--Kaiser-Permanente Dental--Private dentists	Kaiser	447* dental		0%	Aide	Health care part of Kaiser research study. PCC staff not concerned with health services for families; keep no records.
Medical--Public health dept.	Public health dept.	6 pregnant mothers 2 siblings 4 other family		2 5%		Limited resources available have been alienated from PCC and refuse to serve families.

* From FRA reports.

TABLE 25 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--Hospital clinic Dental--Hospital clinic	PCC			8 9%		Nationally known university medical school provides services but no data. Free vitamins.
Medical--Neighborhood health center Dental--Same	Neighborhood health center	7 pregnant mothers 8 siblings 24 other family	1	51 42%	R.N.	Health center has three month waiting period for exams.
Medical--Kaiser-Permanente; Univ. clinics Dental--Univ. clinic	Kaiser University			60 56%		Excellent health services attracted parents to PCC. PCC has influenced training of pediatric residents.
Medical--USPHS Dental--USPHS	BIA		17	160 68%	R.N. L.P.N.	PCC families received medical care prior to program.
Medical--Public health dept. Dental--Same	Public health dept. Comprehensive mobile health unit	86	127	59 70%	Aide	106 hearing tests 106 vision tests 20 Flu shots First time many PCC families examined.

TABLE 25 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Status Reports	Health Personnel Employed	Comments
Medical--Local clinics and health center Dental--Same	PCC comprehensive group plan			0%	R.N. L.P.N.	PCC operating only since 9/69.
Medical--Public health dept. Dental--Same	Public health dept.	56 mothers 65 children 52 older children		15 22%	M.D.	Part-time physician
Medical--University clinic	Donated time			17 20%	2 R.N.	Children have been examined; data not reported.

TABLE 26

Pattern of Provision for Health Services
(NSP Sources - 13 Centers)

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--NSP Dental	Medicaid and NSP health center		32	20 80%	R.N.	Most families on Medicaid. Mothers need dental care.
Medical--NSP Dental--private dentists	NSP PCC		100	34 45%	R.N. + Aide	Pediatrician PCC consultant, good nutrition program. Prenatal classes
Medical--NSP Dental	Health clinic			0%		No children in program.
Medical--NSP	NSP Health center			17 10%		PCC housed with health center, limited cooperation.
Medical--NSP Dental	NSP medical services donated by hospital	4 pregnant mothers 4 siblings 4 other family	28	9 15%		Waiting list for exams. Facility overtaxed.
Medical--NSP	NSP Health center	40 pregnant mothers 44 siblings 67 other family		60 97%	R.N.	All children examined, but no comprehensive approach to health.

TABLE 26 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--NSP (County) hospital, Private physicians Dental--Univ. clinic	University County hospital NSP	56 dental 62 medical	3	30 38%	R.N.	Speech therapist. Health services fairly complete. Nurse conducts health education classes.
Medical--NSP Dental	Health Clinic	118	36	73 50%	R.N.	Red Cross in-service training PCC started counseling center and first aid program.
Medical--NSP Dental	Health center					--M.D. on staff. No families yet enrolled.
Medical--NSP	NSP health center services available to families prior to PCC.	23 pregnant mothers 5 siblings 3 other family	107	39 48%	R.N.	Nurse has alerted rest of staff to health needs of families.
Medical--NSP Dental--University clinic	Health clinic donated time			3		Families receive comprehensive health care but no data reported. (NSP has its own computerized forms.)

TABLE 26 (Continued): Pattern of Provision for Health Services

Services Provided by	Major Source of Funding	No. Exams Reported	No. Referrals Reported	Health Status Reports	Health Personnel Employed	Comments
Medical--NSP Dental	(PCC pays for group health insurance.)	3 pregnant mothers 24 siblings 43 other family	257	28 34%	L.P.N.	Children receive services at local hospital, adults covered by insurance.
Medical--NSP						PCC not funded yet.

sites developed separate health service plans at each site; one of these is shown as a private source and the other as a group source.

COMPARISON OF HEALTH SERVICE PLANS

Due to weaknesses of reporting, it is not possible to determine if the fact that more services are reported by a particular source means that this is indeed the case. There is no doubt that far more services, as well as service to a larger percentage of family members, are reported when private sources are used, but it is difficult to say whether this better reporting actually reflects far more service. As Table 19 indicates, examinations were reported for 34 percent of all family members enrolled in PCC's that utilized private physicians as the major source of health services, but for only 20 percent of those referred to group facilities and less than 19 percent of those using NSP-affiliated centers.

There are so many variables influencing both the reporting of health data and the delivery of services that it is very difficult to compare sources of the service. These variables include the employment of a nurse by the PCC, whether the PCC is in a rural or an urban area, the length of time the PCC has been in operation, and the previous medical experiences of the families enrolled.

As previously mentioned, those PCC's that employ a nurse report far more data than those that do not, so that it is difficult to separate the impact of the nurse from that of the source of service. Eighty-three percent of the PCC's that utilize private physicians for the delivery of service employ a nurse, but only a little more than half of the PCC's using the other two referral sources employ nurses. Further, of the 12 PCC's using private physicians, eight are in rural areas. Many of these rural PCC's not only have been in operation longer than the urban ones, but particularly in the case of the NSP-affiliated centers, these PCC's did not have to wait for health clinics to be built, staffed, and begin operations. In addition, many of the rural families had long unmet health needs because of the extreme shortage of medical resources available to low-income families living in these areas. Families in most urban areas have at least had prior access to health sources, overcrowded and impersonal though they might be. To repeat, all of these variables, together with the fact that we do not have complete information about any of them, makes it most difficult to assess differences between systems of providing health services.

Table 27 shows a comparison of the three sources of service based on qualitative assessments about medical services in the reports of our field staff.

TABLE 27

Number of Centers Providing Various Patterns of Medical Service

	Private	Group	NSP
Comprehensive, All Family Members	7	6	6
Comprehensive, Focal Children Only	1	1	0
Scarce Resources or Overcrowded Facilities	4	1	2
Services Provided Prior to PCC	0	2	1
No Services	0	2	3

Even allowing for the fact that rural centers have been in operation longer than urban centers and are more likely to employ nurses, it nonetheless seems clear that PCC families receive more medical services through private arrangements than through public ones. Not only do they use private resources more readily, but both staff and families appear to be more satisfied with these private sources. One PCC undertook a direct comparison of patients' attitudes toward medical service from private and public sources, and found that parents, while willing to use whatever resources were available, were more enthusiastic about using private physicians than an NSP clinic.

This finding should come as no surprise: being able to select and pay a private physician puts any American patient in a more dignified position than using a public facility with all the implications that being a charity patient implies. Where centers paid private physicians for service, either directly or through an insurance plan, the PCC families were not dependent upon the inevitably overcrowded public facilities. Families got more service, seemed more satisfied with it, and returned more than half again as many reports of examinations and service from private as from public resources. The cost to the PCC was of course higher for those centers that used private medical resources than for those that used either university, USPHS, or NSP services.

Obviously the available resources determined the pattern of service. Those communities that had few public resources, of necessity had to plan to use private physicians. Those PCC's either in Alaska or on the Indian reservation which had complete medical services provided by the USPHS did not need to develop additional services. Those PCC's that were delegated through the NSP's were, for the most part, expected to utilize the NSP health arrangements.

The successful efforts of many of the rural centers to develop and coordinate medical resources for the PCC families are impressive. For the most part these services have been made available to the families through the allocation of budget, but the determination and dedication of the PCC nurses in getting families to these resources are of prime importance.

Impact on Existing Resources

While it is too early to expect that the PCC's will have made much impact on the delivery of medical services in their communities, several PCC's have already been successful in devising new ways of obtaining services.

> --One center was able to negotiate a "PCC morning" each week at a local health center, eliminating waiting and providing a way of insuring and interpreting service.
>
> --Because of the PCC, the pediatric wing of the medical school was redecorated with colorful, attractive child-sized furniture, a television, and games and puzzles. The pastel walls and the casual sofas and chairs are in sharp contrast with the rest of the hospital which is painted the usual grim, institutional green and furnished with church-like pews.
>
> --One PCC is negotiating a modified major medical policy for those parents, who, while eligible for PCC services, are considered ineligible by the local health department.
>
> --Membership on the Policy Advisory Committee by a prominent local physician in one community has sparked volunteer involvement by other physicians in the community.
>
> --More than anything else, the PCC's have exposed the acute need for medical services in many communities previously unaware of these needs. This is always an important first step in developing new services.

SUMMARY

Available medical resources to a considerable extent shape the type of service which a center develops, but almost as important are the employment of a nurse and the attention the director and other staff members give to the health needs of the families enrolled. Unless the staff is alert to the health needs of the children and the parents, the families will use medical services only in times of critical emergencies and will ignore preventive services and health measures. The crowded impersonality of many clinics does little to encourage use by low-income people except when there is a crisis. The reports of our field associates as well as the staff of the centers themselves indicate that ongoing staff support and follow-up must be made if the families are to utilize existing resources regardless of their adequacy.

A nurse may well be the most vital member of the PCC team. While most centers employed a Registered Nurse or an L.P.N., nine urban and one rural center did not. Since the nurse provides staff education on health matters, develops health education and nutrition programs for children and parents, seeks and coordinates resources in the community, and screens children in attendance in play groups, those centers that did not employ a nurse did not develop the full range of health services. The in-center health education programs included prenatal classes, family planning, Red Cross and safety, as well as emergency care of infants and toddlers.

The nutrition programs developed were of three types: teaching parents about adequate diet, provision of food and meals within the center, and in one case, diagnosis of nutritional status.

Health status examination reports were returned for 44 percent of the children under the age of three. The height and weight of these children are within normal limits, but they tend to be on the short and heavy sides of the normative curves. About half had received immunization for DPT and polio prior to enrollment and about a fourth had received smallpox and measles vaccines prior to PCC examination. No tests for tuberculosis were reported for 69 percent of the children. Fifteen cases of tuberculosis were found among those tested. No tests for anemia were reported for 53 percent of the children, but when tests were done with any regularity, about 20 percent of the children were reported to be anemic.

Of the 1526 children for whom Health Status Reports were returned, 32 percent had one or more conditions that required treatment. Of the sample of referrals for treatment subsequent to the initial examination, the largest number of referrals were for acute infections, followed by diagnostic tests, accidents, skin disease, intestinal symptoms and nutritional disturbances including malnutrition.

While many Parent-Child Centers provided medical services for all family members, our reports of these services are very incomplete. Examinations were reported for 25 percent of all the family members enrolled, but it is most likely that the actual number is far larger.

Although most of the centers utilized multiple sources for medical services, twelve used private sources predominantly, twelve used Neighborhood Service Program resources and twelve used other group sources including universities, the U.S. Public Health Service and group plans such as Kaiser-Permanente. Those PCC's that utilized private sources reported examinations on 34 percent of the family members enrolled, while NSP and other group sources provided data on about 20 percent. However, the centers using private resources were for the most part rural, employed a nurse, and did not have to wait for the NSP health facilities to be developed before health care could be delivered. Though the findings are not conclusive, there is a strong indication that more medical services were delivered when private sources were utilized. Families also were reported to be more satisfied with these private sources and more willing to utilize them.

RECOMMENDATIONS

1. Each center or site should have a Registered Nurse on the staff full-time. The experience of centers indicates that the presence of a nurse is directly associated with the amount of service provided, with the development among the other staff of preventive and developmental needs of children, with the implementation of a nutrition program, and with much formal and informal parent education in the area of health. The Staff Activity Reports of the nurses indicate that their time is more thoroughly utilized than almost any other staff member's.

2. Existing resources are most apt to be overcrowded, and therefore PCC's should for the most part plan to allocate funds for the purchase of needed services and medication. Even though PCC's have been effective in getting special attention at existing resources for the families enrolled, many have had to wait three months for an appointment in a public facility. Lack of attention to medical needs of the children may, in the long run, negate the positive effects of the other parts of the program. There are a few communities where there are adequate "existing resources" to coordinate, but these should be carefully identified in the planning stages.

3. Staff members in the PCC's must be made aware of the importance of nutrition, especially protein and iron intake, in the diets of infants and children, and must insist that screening tests are used to identify anemic children.

4. Reporting functions should be separated from service functions. If the purpose of the reporting system is to produce a count of the number of children examined, the number of illnesses found, and the amount of service rendered, then a monthly statistical summary should be substituted for the reports on individual children.

5. If a long-term follow-up study is anticipated, then data on individual children should be collected, but examinations should be done by a team of physicians who visit the centers and examine all or a sample of the children. It is doubtful that data reported by so many independent physicians provide information that is at all comparable.

CHAPTER X

SOCIAL SERVICES

With two exceptions, all the Parent-Child Centers that are open and serving families have implemented some programs to meet the fifth criteria specified: "Social Services to the entire family."[1] These programs have varied along three interrelated dimensions: the staffing of the social service component, the focus of the intervention, and the amount of emphasis placed on the social services component.

STAFFING THE SOCIAL SERVICE COMPONENT

The way in which a social service program is conceptualized in large measure determines the kind of staff employed and the focus of the services. A social service program can be seen as operating in four identifiable problem areas: (1) material, (2) social, (3) psychological, and (4) community. The scope of a social service program is in part determined by the level of staff employed to carry out the services as well as the primary focus of the service planned. A program which operates in all four areas requires a staff more trained, skilled, and varied than most employed in the PCC's.

The social service components of the PCC's are staffed with three different levels of social workers: those with M.S.W. degrees, those with bachelor's degrees, and those with a grade school or high school education. Seven of the Parent-Child Centers are directed by a staff member with an M.S.W. degree. In addition, 13 Parent-Child Centers employed 14 staff persons for positions entitled "Social Worker." Of these, seven were M.S.W.'s, five were college graduates, and two were high school graduates. These, then, are the "professional" level social service staff.

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 4.

The nonprofessional staff members working in the social services component generally are called social work aides. This is the largest single category of staff employed by the PCC's. There are 129 social work aides comprising 17 percent of all staff employed. In addition, those 81 staff persons who are called center or program aides often are assigned some social service activities to perform. Their selection and training are crucial, and both, of necessity, depend upon how the focus of the social service program is defined.

FOUR MAJOR AREAS OF SOCIAL SERVICE PROGRAMS

Material Needs

The type of social service component provided by most of the centers is one designed to meet the material needs of the families. One such program has been described by a field associate:

> There is a general program of social services which focuses primarily on physical and employment needs of the PCC families. Through this program, aides supply food and clothing when emergencies arise, try to find employment or housing when needed, get mothers on the AFDC rolls and refer them for medical or psychological help. Providing transportation is a major part of the social service program.

According to the reports of the staff, nearly a third of all staff time is devoted to meeting these physical needs by providing transportation to services, providing emergency food, aiding with clothing distribution, or assisting a family to find housing. According to the Program Services Reports of the center directors, the two social services provided by nearly all centers are transportation to families and assistance with finding more suitable housing as shown in Table 28.

TABLE 28

Social Services Provided: Material Needs

	% of Centers Providing	Number of Participants			
		Mothers	Fathers	Other Family Members	Whole Families
Transportation to Services	91	Nearly all families served			
Housing Assistance	91	83	13	--	176
Clothing Distribution	46	30	--	--	810
Rummage Sales	31	147	--	--	147
Emergency Food	26	---	--	--	180
Laundry Facilities	26	---	--	--	98
Legal Aid	14	80	21	--	15
Food Stamps	12	54	--	--	---

Providing transportation to families is both one of the most frequent and one of the most time-consuming services rendered by the PCC's. When the programs were first started, some of the social service aides had to be given driver training so that they could provide this service. All but a few of the centers found that they had to lease some kind of a mini-bus or station wagon to provide transportation. Even those aides with automobiles generally own such old ones that they are not reliable enough to provide transportation on any regular or frequent basis. Those centers that did not anticipate the need for a project vehicle lost much valuable staff and program time pending approval of this allocation of funds. As might be expected, the aides in rural areas provide more transportation for families than do the aides in urban areas; even in the urban areas, however, it is very difficult for a mother with small children under the age of three to travel any distance except when portal-to-portal transportation is provided.

Throughout the duration of operations, but particularly when families are first recruited, assistance in finding more suitable housing is a major staff effort. Since the PCC families are almost always those who occupy the "dilapidated and deteriorating" housing in their city or town, efforts to improve their lives must begin with housing conditions. The housing needs have been described in the chapter on the families enrolled in the PCC's and will not be repeated again here. One after the other of KAI's field staff report that housing services often take priority over others: "Better housing is one of the clearest needs of the PCC families...," "it proved impossible to implement any program of infant stimulation until the family was moved to a better house and the baby had a warm place to sleep," and "until a number of the families could be moved out of their crumbling shacks, no other services could be implemented."

PCC staff most often dealt with the housing needs of the families by searching throughout the neighborhood for better housing into which the families could be moved. One center was able to lease houses destined for relocation from the state for one dollar a month. Several centers were able to help some families move into public housing; several rural centers organized the families to help repair and paint one another's houses. In one community a rent strike was proposed but not actually carried out.

A major aspect of most PCC social service programs is the maintenance of a used clothing distribution service. Though question has been raised about the effect on the dignity of the recipients of this used clothing,[1] there is no doubt that many of the older siblings of the PCC children would have been unable to attend school without the shoes and other clothing provided by the PCC aides. The maintenance of the clothing distribution system, including rummage sales, is often participated in by PCC mothers.

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[1] Some centers labeled this service a "clothing exchange," bartering old clothes for newer clothes, as a device to cast the service in the image of a transaction rather than a gift.

About a fourth of the PCC's have set up washer-dryers in the PCC where the mothers can do the family laundry. This is a much needed service in all areas, but particularly in those rural areas where the families do not have running water and the water freezes in the winter time. In one center, the mothers pay a token amount to use the washing machines and the money collected is used to provide for social activities for the families.

Providing food in emergencies and locating ongoing income support through welfare or private aid are prime activities in the social services of the PCC's. In states where welfare benefits are inadequate to meet the basic survival needs of the families, these services take priority over all others. As one social worker stated poignantly, "You can't feed cognitive stimulation to hungry babies."

The material need for the PCC families is probably their most urgent need; it is also the type of service aides can most readily be trained to deliver. Providing transportation, distributing food and clothing, taking families to welfare or employment agencies to file an application, or helping a family locate and move into another house are skills already held or readily taught to any intelligent staff member regardless of previous education or work experience. Since the services most urgently needed by the families are those the staff is most capable of delivering, meeting these physical needs is the kind of service most often provided by the social service staff.

Social Needs

Every human being has need for social contact with others--with neighbors, friends, peers. Many of the families enrolled in the PCC's had long been isolated. Some were physically isolated because they lived in remote areas, had no transportation, or no one with whom to leave the children. Others were isolated because of personal maladjustments. Still others were isolated because of personal life situations such as the young unwed mother who had separated from her family and lost contact with former friends. Staff members in the social service programs of the PCC have provided a number of services and programs aimed at reducing the social isolation of the families.

Programs to meet the social needs of the families have been provided within the PCC itself, by utilizing community resources, and through the home visits of the aides. The center-based programs include not only socials, coffee hours, dinners, or other clearly social activities but also any other activities in which family members participate and which serve to bring together isolated individuals. While particularly important to mothers and to young, often unwed, pregnant girls cut off from their previous friends, these programs are participated in by all family members. It is in these kinds of activities that the fathers and whole families have participated most as indicated by Table 29.

The tabulation reports the number of activities provided and the number of people involved, but the reports of the field staff reflect the importance of these activities to the families involved. As they have reported:

> The mothers now get out of bed in the morning. Before the PCC, they had nowhere to go and no one ever came to see them, so they used to sleep most of the day. Now they get up and go to the center.
>
> One mother told me, "I've gotten out of the house more in the last six months since the PCC came than I did in the five years before."

TABLE 29

Social Services Provided: Social Needs

	% of Centers Providing	Number of Participants			
		Mothers	Fathers	Other Family Members	Whole Families
Socials, Dinners, Game Nights	91	326	52	242	547
Arts and Crafts	34	140	30	45	--
Trips, Camping	29	329	--	264	80
Charm Classes	20	110	0	6	0
Movies	20	56	30	16	112
Teen Activities	12	--	--	62	--
Library and Toy Loan	9	8	7	--	10

Another of the field staff wrote:

> The PCC serves as a community center where families feel free to drop in when they are lonely or have no one to talk to. Here they gather to talk, play cards, or help with the children.

At one PCC, the families shared Christmas dinner and exchanged gifts afterwards.

In addition to these center- and community-based activities, the social needs of the families are met by the home-visiting component. Even when the focus of the home visits is to provide stimulation to the infants, these visits provide an important break in the isolation of many families, particularly mothers. As one mother said, "Except for my baby's teacher, nobody ever comes to see me."

While developing programs to meet the material and social needs of the families, most centers have simultaneously met the sixth criteria established for the PCC's:

> A program designed to increase the family's participation in the neighborhood and community both in terms of:
>
> (a) Taking advantage of the opportunities it offers, becoming familiar with and knowledgeable of its resources, and
>
> (b) Stimulating the family to become participating, responsible and significant members of the neighborhood and community.[1]

The social service staff, together with the health aides and the parent educators, makes referrals and provides transportation for individual families to a wide variety of agencies and services. In addition, the social service staff has developed trips and tours of various community agencies and facilities for groups of PCC parents. About a third of the PCC's have organized these group tours of public agencies and hospitals to increase the familiarity of the parents with these resources. It is assumed that once familiar with these resources, the parents will be less hesitant about utilizing them. This is frequently the case, particularly when families have been very isolated from community resources in the past.

Every PCC sponsors some kind of parents' meetings as a first step in stimulating family participation in community activities. These meetings have been described in the chapter on parent activities. Almost every PCC has a Policy Advisory Committee where more outgoing and aggressive parents can gain additional experience in making community decisions. A total of 281 mothers and 56 fathers are reported to be serving on these policy-making committees. In addition, a few parents from each PCC have been selected to represent their centers at each of the two national Head Start conferences as well as at the PCC mini-conference held in the fall of 1969.

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[1] Office of Economic Opportunity, op cit., p. 4.

Psychological Needs

Social service programs can be staffed to provide counseling and psychotherapy within the agency itself or to use the agency staff as case finders who refer clients with problems to appropriate resources in the community. In order to provide the service within the center itself, professionally trained staff must be employed and medical supervision usually must be provided. Only about five of the Parent-Child Centers have been able to meet these conditions to provide the psychotherapy within the PCC itself. Most centers use either their bachelor's level social workers or the social work aides as case finders. That is, they are trained to recognize problems of an intrapsychic nature which may range in intensity from mildly neurotic to psychotic. When these problems are recognized, the aides find an appropriate agency for diagnosis and treatment and work with the person to get them to accept a referral.

Because only a few PCC's are staffed in such a way that they can provide intensive psychotherapy for families with psychological problems, referral to appropriate agencies is an important service of the social work aides. While only 26 percent of the Parent-Child Centers report that they have made referrals to family counseling and psychiatric agencies, 91 percent of the PCC's report referrals to other agencies, some of which may have been for psychological treatment. The numbers of family members referred for such reasons are shown in Table 30.

TABLE 30

Social Services Provided: Psychological Needs

	% of Centers Providing	Numbers of Family Members Referred			
		Mothers	Fathers	Other Family Members	Whole Families
Walk-in Clinic	9	34	0	0	0
Referral to Family Counseling	26	76	14	0	24
Referrals to Other Agencies	91	(nearly all families served)			

The role of the social work aide in the referral process is well described in the following report from one of the field observers:

> All families enrolled are assigned a multipurpose worker who is responsible for assisting them with their problems. When the multipurpose worker runs into a problem which he cannot handle, the situation is brought to the attention of the Social Services Coordinator....[When the appropriate referral has been found]...the multipurpose worker accompanies the parent to the referral agency, and all referrals are followed up until the problem is successfully resolved.

Thus the social work aide, or in this case the multipurpose worker, serves not just as a case finder, but as a catalytic agent and in a supportive role to maintain the family member in treatment.

The kinds of referrals made are of course in large measure dependent upon the resources of the community. Those rural areas with scarce resources do not provide PCC staff with many possibilities for referrals. In general, urban areas have a wider range of resources. Although many agencies are overcrowded and have waiting lists, staff members with sufficient knowledge, skill, and perseverance generally can get access to these resources for the families in need. Without the skills and dedication of the PCC social workers many of these resources would not be made available to the PCC families.

In general, the PCC's have made referrals to any agencies that were available and would accept families meeting the agency criteria, but some PCC's made formal arrangements to provide for the psychotherapeutic needs of the families enrolled. Some made these arrangements through medical schools, university hospitals, or community mental health agencies. One of the most extensive treatment arrangements made by a PCC was the securing of a local matching contribution of $37,360 in therapeutic services for both outpatient and inpatient treatment of severely disturbed preschool children.

The five Parent-Child Centers that provide intensive counseling and psychotherapy for PCC families have staffed these services in three different ways:

1. Three centers have employed professionally trained social workers and psychologists to provide the psychotherapy.
2. One has recruited volunteer therapists from a university to provide marriage counseling and treatment at the PCC.
3. One center has had a walk-in clinic developed by Ph.D. candidates in psychology who are training and supervising the social work aides to provide treatment.

Of the three PCC's that employ professionally trained social workers to provide psychotherapy, two are delegated to traditional casework agencies, and the third to a school of social work. In addition to the social workers employed by these PCC's, two of the centers have psychologists and psychiatrists who either volunteer time or are employed by the PCC itself. Because of prior professional arrangements and contacts by the staff of these agencies, many treatment resources have been provided the families enrolled. An example of the range of therapeutic services provided at one of these centers is given by one of the field staff:

> The core of this program is the home visits of the social work aides together with the counseling and psychotherapy provided by the social workers on the staff of the PCC as well as other agencies. Families are sometimes referred to the community mental health clinic for psychotherapy, but they are also seen within the center. A Spanish-speaking therapist meets weekly with two groups of mothers for group therapy sessions. Both crisis intervention and long term therapy are being provided. Play therapy is provided for a few children by a psychiatrist who volunteers time....This PCC is really an excellent model of the attempt to alter the lives of the poor through treatment services provided by nonprofessionals as well as professionals.

The Parent-Child Center that has recruited volunteer therapists was assisted in this by the University Affiliate. This PCC is in a rural area, although not a remote one. However, many of the families in need of treatment were reluctant to seek help in the big institutions of the nearby city. The willingness of the professionals to travel to the PCC allowed these families to receive the needed marriage counseling and individual or group therapy. Staff at this PCC is most enthusiastic about the effects of the services provided by these volunteer therapists.

The third method of staffing a counseling program within the PCC is a walk-in clinic developed by a psychology interne. During the spring of 1968 this student was on field placement just as the PCC program was being planned. After lengthy sessions involving the PCC planning committee and later the staff, the university, and a variety of community agencies, the walk-in clinic was established and the PCC aides trained in interviewing techniques by both the psychology graduate students and some in social work who subsequently were placed in the walk-in clinic for their field experiences. As described by one field observer:

> The walk-in clinic will be started again as soon as the PCC moves to its new quarters. This clinic mostly offered crisis intervention and supportive treatment and served as a diagnostic and referral program for those families who needed help and "walked in" to ask for it. There was also some information-giving and suggestions regarding how to help the child. The program was operated by two psychologists on a part-time basis and two PCC psychology aides who were being trained to give some tests and to do interviewing.

Environmental or Community Needs

This aspect of the social service component is generally called community organization and includes the development of services, improving the quality of existing services, and attempting to make the focus of services more relevant to client needs. The staff functions in the community organization component, not just in the area of welfare services, but also in health, education, employment, housing, or any area of client need. Virtually every PCC utilizes a wide range of available resources in the service aspects of the program, but in the community development component, a PCC would attempt either to develop new resources, bring about the reallocation of previous resources, or change the delivery of services to enhance those received by PCC and other poverty families.

Although the Parent-Child Centers were funded through the Community Action Agencies, few directors seem to perceive their programs as "change agents" of the institutions or the communities as indicated by their responses to the questionnaire on center policy priorities.[1] As can be seen on the two tables in Appendix D, service goals took precedence over the goals of community change.

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[1] See Appendix D.

No center director ranked "neighborhood change" above the third rank in goals, but nonetheless a number of changes were brought about by centers which did not establish community change as a goal. These changes are discussed in the chapter on program outputs. Of the four center directors who ranked neighborhood change in the third position, three developed programs aimed at the reallocation of services or a change in the way services were delivered. In one center, a concerted effort was made to develop a branch of the health clinic within the housing area served by the PCC. In a rural area parents organized to pressure the school board to improve classroom conditions, to reduce the cost of lunch, and to prevent teachers from spanking their children. In a third, the director of the program for teen-age mothers confronted a number of local institutions including the public schools and the NSP health center to insist that these agencies deliver the services they are funded to provide. In many of the PCC's with a highly "service" orientation, some of the staff function in the role of "ombudsman" to attempt to insure more or more relevant services for the families enrolled.

Of all the PCC's only one has attempted confrontation techniques as a strategy to bring about social change. At this PCC, confrontation with doctors, landlords, and the CAA itself has been attempted. Somewhat surprisingly, even those PCC's located in Black urban ghettos of the North are utilizing service and education rather than community action as strategies to bring about individual, community, and institutional change.

VARIATIONS IN EMPHASIS WITHIN THE SOCIAL SERVICE COMPONENTS

Some Parent-Child Centers allocate nearly all the staff time to providing social services to the families enrolled while other centers place little emphasis on these services. The amount of emphasis placed on social service is related to whether the primary focus of the program is on the child under three, on the family, on the parents, on the institutions of the community, or on the staff of the PCC. The amount of emphasis on the social service component is also related to the educational background and training of the director.

Those Parent-Child Centers that focus on the family as a unit provide more hours of social service for families than do those programs that focus on the child under three, the parents, or the staff. Two centers have no social service programs at all. One of these provides full-time day care at each of its two sites for children under three, and the other provides only job training for teen-age mothers with no services for children at all. Eight centers do not employ either a social worker or any social service aides, although at six of these centers some social service support is provided by other staff members. At these centers the staff spends less than ten percent of their time on social services, and far more in child care. At the other extreme, one PCC employs four staff members with M.S.W. degrees--the director, the supervisor, the research associate, and the social worker--as well as ten social work aides. Almost the entire focus of this program is on families and in meeting their social and psychological needs. Little or no staff time is spent on the social, educational, or medical needs of the child under three.

While some field observers reported that a disproportionate amount of staff time was allocated to social services and not enough emphasis was placed on medical or educational services, others felt that the severity of the problems of the selected families necessitated this distribution of time.

A question was raised by two field associates about the intervention strategy of two of the centers. Both of these centers have developed programs focused on treating the psychological problems of the families. The assumption behind these programs is that the families enrolled are "sick" and that social services, counseling, and psychotherapy will "cure" them. These models also assume that if given sufficient treatment and support, the parents will be able to provide the necessary "parenting" to meet the needs of the children. It is somehow surprising to find this model of intervention funded through a Community Action Agency, for much of the philosophy of the Economic Opportunity Act developed as a reaction against this interpretation of the etiology of poverty. The question raised by these two field staff is not whether a Parent-Child Center should have a social services component, but whether social services should be the only component.

SUMMARY

All but two of the Parent-Child Centers have established social service programs designed to meet the needs of PCC families in one or more problem areas: material, social, psychological, or community. Most social services within the PCC's are provided by nonprofessional staff.

The 129 social service aides, together with the seven professionally trained supervisors, the five bachelor's level social workers, and the two nondegree supervisors, comprise the largest group of staff assigned to any program within the Parent-Child Centers.

The majority of the services provided by the social service workers are in one of two fields: (1) those designed to meet the material or social needs of the families, and (2) case finding, referral to services, and transportation to those services. Important activities toward meeting material needs are assistance in finding more adequate housing and provision of emergency food and clothing. Meeting the social needs of the parents through a variety of center and home programs is also a significant effort of the social service staff. Many of these activities might more appropriately be classified as recreation, but nonetheless they meet the social needs of adults as well as children.

While most Parent-Child Centers refer families to counseling services outside of the center, five also provide considerable treatment within the centers. These counseling and psychotherapy services are staffed by both paid and volunteer professional staff. One center has developed a walk-in clinic where emotionally disturbed adults may receive treatment.

While community action is not a major focus of many of the PCC's, important community changes have resulted in a number of places. These changes are described more fully in chapter on program outputs.

RECOMMENDATIONS

Most of the recommendations made by our field researchers about the social service component were those that applied to staffing of the PCC's in general.

1. More careful selection of aides should be made; these aides should be selected for ability to learn and perform rather than for their need for a job.
2. The tasks of the aides must be clearly specified and their training should be specific to social services rather than general to all PCC jobs.
3. Where possible, professional staff should be employed to train, supervise, and support the nonprofessionals.

It is also recommended that the social services component be integrated into the total PCC effort and communication between the social service staff and the education staff be developed. A subsequent section of this report deals in more detail with how social service programs related, or failed to relate, to the entire center strategy. As a prelude, it may be said that center planning must be consistent with the needs of the clientele and the resources available and must integrate the social service component into the overall strategy.

CHAPTER XI

SELECTED PRELIMINARY INDICATIONS OF PARENT-CHILD CENTER OUTPUTS

RESEARCH AND EVALUATION ACTIVITIES

It has been recognized that definitive conclusions as to the impacts of Parent-Child Centers are not possible at this early stage of the program's development. This section of the chapter describes the research and evaluation requirements that centers should meet so that PCC impacts and effectiveness can be assessed over time. It also describes what is being done in this field.

Subsequent sections of this chapter provide selected interim findings that are available from the current experience and that focus particularly on the developmental progress of the children and other family members.

The PCC criteria state that centers should undertake:

> A program of research and evaluation developed in cooperation with an appropriate institution, such as a university or a clinic, and designed to:
>
> (a) Describe what happens in the center and provide necessary statistics on operation;
>
> (b) Measure developmental progress in the child, parents and other family members and community;
>
> (c) Result in recommendations on program content and methods;
>
> (d) Produce packaged instructional materials and handbooks on how to operate this type of program; and
>
> (e) Adequately assess the operational costs of running similar programs.
>
> It is expected that each center's E & R program will be related to a comprehensive research and evaluation sub-committee organized by OEO, the Children's Bureau, Public Health Service, and the Office of Education of the Department of Health, Education and Welfare.[1]

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[1] Office of Economic Opportunity, Project Head Start, Parent and Child Centers Criteria, July 19, 1967, p. 5.

To meet these ambitious criteria, each Parent-Child Center selected a University Affiliate at the time of submission of its first proposal. During the course of the first program year a number of PCC's changed Affiliates either because the Affiliate could not participate as expected, or because the PCC was not satisfied with the initial arrangements. By the end of the first program year only one PCC had no formal arrangements for a local evaluation, two had contracted with a private research group and all the other PCC's funded (32) had contracted with a college or university. For most of the PCC's, the amount allocated to carry out this research was $8,700 a year.

As might have been expected, no local evaluation even attempted to meet all of the specifications established in the criteria. To have done so would probably have required a budget as large as that allocated to the operations of each of the PCC's. While there was some overlap in the types of programs planned by the University Affiliates, they could be divided into four general categories, which are shown in the table on the following page along with the completion status as of December 1969.

Only one of the PCC's was funded to conduct a program of basic research; in this case, the institution selected as the delegate agency was also designated as the University Affiliate. The plan, now in process, is to write a linguistic analysis of local Mexican-American dialect, study the language acquisition of young children in a bilingual environment, and develop a service program.

The largest number of University Affiliates (12) undertook to measure the developmental progress of the PCC children, parents, or staff. Of these, five had not yet implemented the plan even to the extent of gathering the pretest data, three were in process, three had completed the studies and written reports, and the status of

TABLE 31

Status of Local Evaluation

Primary Relationship or Type of Evaluation	Total Number	Not Yet Implemented	In Process	Completed	Unknown
Basic Research	1		1		
Pre- and Post Testing to Measure Developmental Progress, Program Impact	12	5	3	3	1
Evaluation of Organization	7	1	2	4	
Consultation, Technical Assistance, Training	11		8	2	1
No Local Evaluator	1				1
Plans Unknown	2				2
Totals	34*	6	14	9	5

* Data were available for 34 of the 36 centers.

one is unknown. Among the techniques specified to measure the developmental status of the children were: use of the Peabody-Vineland, the Bayley Scales of Infant Development, the Cattell Infant Scale, the Brody Aesthetic Perception Test, the Denver Developmental Test, and the Lorge-Thorndike DIQ. To test adults, the Gordon "How I See Myself" and the DARCEE Vocabulary Tests were used. In addition to the testing planned, four of these University Affiliates also provided consultation and training to the PCC's, but the major project planned was the pre-post testing assessment program.

Seven of the University Affiliates undertook descriptions of the organization of the Parent-Child Centers, an assessment of the staff and of the program. Of these, four had submitted written reports, two had submitted interim reports, and one had not yet begun work on the evaluation.

Consultation, technical assistance, and staff training, both initial and in-service, were the major contributions of 11 of the University Affiliates. Eight of these arrangements are still in process, two have been terminated, and the status of one is unknown.

There was a considerable range of degree of PCC staff satisfaction with the roles assumed by the University Affiliates. In general, but not exclusively so, the Parent-Child Center staff reported greater satisfaction with University Affiliates who provided consultation and assistance and generally facilitated the work of the PCC than with those that attempted an assessment of the organization or the impact of the programs. Resentment of the organizational assessments submitted have been high in three of the four cases where these reports have been completed. There has been continual resistance and foot dragging by the staff toward any research design that would measure the PCC's impacts on the children, the staff, or the families. Five of the University Affiliates who planned such programs have not even been able to gather the baseline data. Dissatisfaction of staff was great enough that there has been considerable change in the designation of University Affiliates for the refunding of the PCC's.

DEVELOPMENTAL EXAMINATIONS OF INFANTS

The Bayley Scales of Infant Development

The value of any childhood intervention program must be judged in terms of its effects on the behavior of the children who have been the targets of such an intervention. Long-range indices of impact, including mortality, success in school, and vocational adjustment can easily be obtained, if one is willing to wait. However, shorter-range indices (more immediate measures) of the effect of PCC intervention are difficult to obtain because of the difficulty in measuring the development of children under three years of age. School achievement or vocational success are meaningless measures. Direct questioning of these children and infants regarding the effects of the intervention program upon their living patterns and behavior is similarly inappropriate.

Perhaps an even more serious difficulty in evaluating an early childhood intervention program is the impossibility of channeling the child's behavior to situations directly relevant to his experience within the program. This problem arises not only because one cannot always expect infants and toddlers to follow verbal commands, but also because children in different centers may not, and in many cases do not, receive similar experiences. Different centers provide different social climates and different experiences for their target children.

In order to evaluate the intervention in terms of the behavior of children who have been exposed to different sets of stimuli, and from whom different sets of behavior have been elicited, the behavioral measures used must cover a broad range of responses so that any relevant changes or differences in the children's responses can be detected. In the present evaluation a psychometric device was chosen for this purpose (i.e., a systematic procedure for comparing the behavior of children). Psychometric tests are adaptable for many purposes. Although psychometric tests are useful for selection and classification of individuals, this is not an area of present concern. We are not selecting individual children to enter a program, nor are we classifying or diagnosing each child's level of adjustment in order to determine what program he should enter. Rather than making decisions about individual children, the present purpose is to evaluate the effects of different treatments (in this case, the treatments are the intervention programs at the different centers).

The particular test chosen as an evaluative measure was the Bayley Scales of Infant Development (BSID). The evaluation of the development status of infants necessitates the use of special methods and procedures because children this young may not respond to directions. The Bayley Scales were selected because they make an effort to obtain measures of relevant behavior variables by presenting attractive stimuli, thereby holding the child's interest and fostering his participation. The Bayley test consists of two main sections, the mental scale and the motor scale. The mental scale of 163 items attempts to assess: (1) sensory-perceptual acuities and discriminations; (2) memory, learning and problem-solving abilities; (3) vocalizations and early verbal communications; and (4) early evidence of abstract thinking as reflected in the ability to form generalizations and classifications. The motor scale, consisting of 81 items, assesses the degree of body control and coordination, both of large muscle groups and of finer manipulatory muscles of the fingers and hands.

The range of items on the mental scale includes appropriate responses to a bell (e.g., turns head to sound), responses to being lifted (e.g., anticipatory excitement), responses to a rattle, a red ring and a red light, vocalizations and sounds (e.g., vocalizes "da-da" or equivalent), verbal comprehension (e.g., points to five pictures), and social responses to persons (e.g., social smiles when the examiner talks and smiles). The motor scales include motor responses while held upright in arms (e.g., holds head steady), sitting responses (e.g., sits alone steadily), finger-hand coordination (e.g., cube grasping), balance (e.g., standing on one foot), and walking responses (e.g., walks up stairs alternating forward foot), and jumping responses (e.g., jumps off the floor with both feet).

Within each group, responses on the BSID are arranged in developmental order. If a child passes a more difficult response within a group, he is also credited with passing the easier responses. For instance, on the motor scale in the group labeled "upright progress in walking," if the child passes Item 46, "walks alone," he is also credited with passing Items 45, "stands alone," and 43, "walks with help." The mental scale is scored similarly.

In addition to the formal items, ratings of various aspects of the mother's and the child's behavior are obtained for qualitative assessment. The BSID takes approximately 45 minutes to administer. The child is tested while the mother or mother-substitute is present. The examiner takes great care to establish rapport with the child. Every effort is made to record the child's optimal level of responding. If the examiner cannot elicit a response to a particular item, he can ask the mother to attempt this task. The order of item presentation can be adapted to the responsiveness of the particular infant the examiner is testing. A child is scored for an ability manifested at any time during observation, even if the child failed to manifest the behavior when a specific opportunity was offered to him. Any behavior of the child that is observed by the examiner can be scored.

The examiner's task is to establish the relevant range of successes and failures for each child. Both the basal level (i.e., the item preceding the earliest failure in terms of age placement) and the ceiling (i.e., the item representing the most difficult success) must be determined. Items on the test are arranged in terms of age placement (i.e., age at which 50 percent of children pass a given item). Also given are age ranges, which provide estimates of the ages at which each item is passed by five percent and 95 percent of the children in the sample.

The BSID shows a reasonable reliability, a necessary attribute of any psychometric test. That is, children earn approximately the same scores on the test each time they are tested. The amount of increase on retest scores is uniform for each child and thus is predictable. Reliability is dependent on the freedom of the scores from chance error.

Raw scores for both scales of the BSID consist of the total number of items the child has passed, including all items below the basal level whether administered or not. The Mental Development Index and the Psychomotor Development Index are derived from raw scores on the mental and motor scales respectively. Each of these indices is derived by converting the distribution of raw scores at each age level into a set of normalized standard scores having the same numerical characteristics as the familiar Binet IQ score (i.e., a mean of 100 and a standard deviation of 16). The value of such a score conversion is that although children of different ages cannot be compared directly through raw scores, they can be compared through use of standard scores. Moreover, a child's differences in scores at different age levels can be assessed. A normalized standard score of 116 on the Mental Development Index always indicates that 84 percent of children of a similar-aged normative group scored lower than the child obtaining this score. This score of 116 indicates the same facts whether a child is four months old or 24 months old.

An adequate psychometric test requires that the sample on which the test norms are based is representative of the population for which the test is devised. The standardization sample of the BSID includes accurate proportions of children from two months through 30 months in selected strata of the U. S. population, controlled for sex and race within each age group. Controls were also instituted for residence (urban-rural) and education of the head of household. Normal children living at home composed the sample of over 1,200 children. One of the highlights of the test is that research (Bayley, 1965) has shown that the effects of demographic and socioeconomic variables, such as sex, birth order, geographical location, parent's education, and ethnic group, were negligible. The only significant ethnic group difference that appears on the test is the tendency for Negro children to obtain slightly superior scores on the motor scale from ages 3 to 14 months.

What the test does is to spell out, given the chronological age of a child in months, how this child compares to norms established by the standardization sample (described above) of similar-aged children throughout the United States.

There are several areas in which this developmental scale is not prepared to venture.

1. The BSID test does not endeavor to compare groups of children differing in their socioeconomic or ethnic backgrounds. Initial standardization procedures with the tests showed that differences in such demographic variables do not affect test scores.[1]

2. The Bayley test does not measure intelligence. It is a test of developmental level, rather than a test of intelligence. While some correlation exists between the BSID scales and children's

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[1] Manual: Bayley Scales of Infant Development (Thy Psychological Corporation: 1969), pp. 9 and 10.

intelligence tests (e.g., Stanford-Binet), in general, the BSID measures behavior of children much younger than do the children's intelligence tests. Only children who score in the higher limits of the BSID can be given a common intelligence test. Therefore, the sample of children used to assess the relationship of the Bayley scales and intelligence tests is a biased one composed only of children scoring at the highest extremes of the developmental test.

3. In fact, no assumption that the BSID measures anything except maturational level of the child is made. The relationship of the test to a child's eventual success in life has not been determined. It is not necessary for our purposes that the test directly predict anything. All normal children can pass all items of the test at some point in their development.

Our testing procedure does allow certain types of analysis. First, we can compare rates of development of PCC children with development rates for the average child. In this design, a control group is not necessary because of the standardized norms that tell us what the average or mean score is for children at each age level. We know how the "average" child (the child who scores at the 50 percentile) aged 12 months should score as compared with the "average" child aged 24 months. Therefore, if a child's score on the test at 12 months (before he became active in a PCC) the changes in his scores on the mental and motor scales can be contrasted with the average change for the child over a year period as indicated by the norms. Since the raw scores are converted into standard scores, this is very simple to do. The average standard score for both ages is 100. If a child has a standard score of 84 at 12 months (i.e., only 15 percent of children in this age group score lower than he) and a standard score of 116 at 24 months (i.e., 84 percent of similarly aged children score lower) this would suggest that his rate of developmental change over the intervening 12 months is unusually high. If many PCC children showed such changes it could be hypothesized, with reasonable certainty, that the changes resulted from the intervention of the PCC program.

Another aim is to examine differences in changes occurring between different centers in order to assess the impact of various PCC's upon the behavior of their target children, thereby providing an indication of the effectiveness of each center. For instance, if the mean changes in Mental Development Index for all children in one center is 0.10 and another center shows a mean change of 16.50 we can hypothesize that the first center is having less effect on the children's behavior than the second center.

As an instrument for evaluation, we believe that the Bayley Scales can provide information regarding a number of areas. First and foremost, they indicate something about the impact of the intervention of the program on a broad range of developmentally related behaviors of individual children. This is indicated by change scores for each child as compared with national norms from first to second administration of the scales (i.e., it allows us to assess mean changes in scores). Second, these scales indicate the current status of the children involved in the program compared with a national normative sample. Have these children shown enriched behavioral responses as compared with the majority of children? Do they fall at the 30th percentile or the 50th or the 80th? Third, the test allows us not only to evaluate the overall effect of the program, but also to compare children in various centers. We can see how much progress has been made by children in different centers with their different approaches. Such a procedure may indicate which techniques are most effective in enriching the experiences and thus enriching the behavioral repertoire of infants and young children.

Finally, the Bayley was designed to lead directly into the Stanford-Binet Intelligence Scales, with test items overlapping at the 30-month level. In this study, we used the Binet for all children over 30 months of age, and in the post-test data the Binet I.Q. scores are treated as though they are Bayley Scores, where necessary. Because of this relationship between the Bayley and the Binet, it is a particularly useful combination for longitudinal studies.

The Sample

During the course of this evaluation 109[1] children in six centers were administered the Bayley test early in their enrollment in their respective centers. Of this number 79, or 72 percent, were available for reexamination an average of forty weeks later.

These six centers do not constitute a "representative" sample of Parent-Child Centers. The purpose of this test administration was primarily illustrative, and it was necessary to be able to retest the children within the time span of this contract. Since centers opened so slowly, we were forced to use the first six centers that had children available.

Of these six centers, three are urban and three are rural; one has an all Black population, one an all Anglo population, two have predominantly Hispanic and Indian populations, and two are fully integrated. One has a large day-care component, and another provides almost no direct service to children. The others provide various "mixes" of group and individual service to children and their parents. Two of these six centers are in the southeastern United States, and one each are in the northwest, southwest, midwest and northeastern states. All in all, therefore, they do include a wide selection of programs, populations and places, though not in the same proportions as exist in the whole program. The variables associated with their opening early do not, we believe, particularly affect the kinds of children who are served.

All of the children whose test scores are included in these data were tested and retested by the same psychometrist, who had been trained by a member of Dr. Bayley's staff. The test program was initiated prior to publication of the BSID, and we are indebted to The Psychological Corporation for making sets of the test kits available to us before publication.

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[1] An additional four children were examined but were untestable.

We had hoped, originally, to expand the sample, since three centers outside of our sample of six had employed psychometrists and planned to administer the BSID to all of their children. We provided the test kits and scoring sheets for them. Unfortunately, two of the centers diverged so radically from the standard test procedure that their data were unusable. For the third center we provided training as well as materials, but this center did not enroll children until quite recently, and so comparable retests could not be administered.

All in all, we collected usable test records for 109 children, of whom 79 were available for reexamination. The sex and ethnic distributions of the original group and those available for retest are presented below.

TABLE 32

Percentages of Children by Sex and Ethnicity in Pretest and Retest Samples

	Boys		Girls		Total	
	Pretest	Retest	Pretest	Retest	Pretest	Retest
Anglo	15	15	15	10	30	25
Negro	24	25	17	23	41	48
Hispano	15	14	15	13	30	27
Total	54	54	47	46	101	100

Attrition was evenly divided between boys and girls but was markedly related to ethnicity. Only 16 percent of the Black children initially tested were not available for retest, but 39 percent of the Anglo children, and 36 percent of the Hispanic children originally examined were no longer in the centers. Overall, this reduced the Anglo representation in the final sample to 25 percent and increased the percentage of Negro children to 48 percent.

All of the statistical treatment which follows includes only those children for whom both pretest and retest data are available. These data on attrition of the sample are included for their basic interest; they point to a trend that we believe is important. The present centers are gradually becoming all Black in situations where this is demographically possible. The self-reporting by the centers does not reveal this trend quite as clearly because many centers retain children on their rolls even though they are no longer receiving service or participating in the programs. Indeed, even in this sample we found that some of the parents of the children told us they had not been in touch with any center activity or service since the initial psychometric examination. In one center, all but three of the parents reported that their only contact with the center in the ten-month period between tests was to fill out a medical reporting form for our reporting system.

A detailed description of the test sample is contained in Appendix E. Briefly, the test sample has the following characteristics:

--Fifty-five percent are boys.

--Forty-eight percent are Black, 25 percent are Anglo, and 27 percent are Hispanic.

--The mean age at initial testing of boys was 14 months; at retest 24 months. For girls the means were 11 1/2 months and 21 1/2 months. There was little variation between centers. The range of ages was two months to 26 months at initial examination.

Following is a brief statement of findings of the testing program.

--On the whole, more boys scored below the normal range than did girls, on both the mental and psychomotor indices.

--There does not appear to be any systematic relationship between test scores and reported family income. This independence of relationship is also true for the standardization sample.

--On initial testing, the mean Mental Development Index score for all children was 77.6, which is almost two standard deviations below the national mean. The mean score on the psychomotor index was 90.4, which is within the normal range. The range of initial scores was quite wide--ranging from 28 to 136 on the mental scale, and 35 to 124 on the psychomotor scale. Both curves are skewed toward the lower end of the distributions.

--There were no differences in mean scores by ethnicity, rural or urban residence, or rate of infant mortality in the county in which the center is located.

--In the initial testing, we found a steady decline in mean scores accompanying increased age of the children.

--At initial testing, the children scored higher on the motor scales than the mental scales. The mean difference was the same for both sexes.

--Sex differences in mean scores appear to be an artifact of the sample since, on the whole, the boys were older than the girls. When controlled for age, these differences disappeared.

Comparisons With Standardization Sample

Control groups, in the sense used in experimental studies, are neither necessary nor appropriate in a study of this kind, nor for this use of test scores. This is because the national norms and standardized scoring system provide a "normal control" of infants and toddlers not enrolled in Parent-Child Centers. The fact that this instrument yields scores independent of socioeconomic status and the slight advantage of Negro youngsters in the motor area makes sensible the use of these scores as a device for indicating whether the diverse kinds of interventions represented by centers are associated with change in developmental status.

In addition to the national norms, we were able to locate data for another independent group of infants. As part of "The Collaborative Study of Cerebral Palsy, Mental Retardation and Other Neurological and Sensory Disorders of Infancy and Childhood," more than 38,000 infants between 7 1/2 and 8 1/2 months of age were examined with the Bayley Scale. This national study, a cooperative effort of fourteen institutions and sponsored by the National Institute of Neurological Diseases and Blindness,[1] has been described in a variety of publications, including one entitled "The Collaborative Study..." and published in two volumes by the U.S. Department of Health, Education and Welfare in March 1966. A wide variety of measures and information was gathered on each child and family, including a socioeconomic status measure. These results and the PCC data are compared in the discussion that follows.

Results

Only the 79 children who were evaluated on both the motor and mental scales at each of the two administrations of the test are included in the following analysis. Results indicated that all groups of subjects showed a positive gain in both MDI and PDI scores from first to second tests. Both overall gain scores from pretest to retest and gain scores for specific groups of subjects (based on sex, ethnic group, age, or center) showed positive mean gains.

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[1] Now called the National Institute for Neurological Diseases and Stroke.

Overall Differences

Overall differences are presented in Table 33.

TABLE 33

Overall Pretest and Retest Scores

	N	Mean Pretest	Mean Retest	T Test of Difference
MDI	79	77.4	87.7	3.9*
PDI	79	91.1	98.4	2.2**

* p < .01 (one-tailed test)

** p < .025 (one-tailed test)

Both MDI and PDI retest scores differ significantly from pretest scores (i.e., a difference as large as the ones obtained can be expected by chance less than one time in 100 for the MDI scores and less than 2.5 times in 100 for the PDI scores). However, a somewhat greater gain in MDI scores than in PDI scores occurred. Since MDI scores were lower than PDI scores on the pretest, this result could have been anticipated. The greater MDI gain could be due to a ceiling effect on PDI scores (i.e., if a child is closer to the highest level of development measured by a developmental scale he does not have as great a range of possible improvement in developmental level as if he is at a lower level of development). The higher the initial score, the smaller the greatest possible increase in score, and therefore the smaller the expected increase. However, as the means of both sets of scores were below the standardization means, the larger gain for MDI scores may simply be due to a regression-to-the-mean effect.

Can we then expect MDI scores, which were below PDI scores on the first testing, to catch up with PDI scores on the retest? As can be seen from Table 33, this is not the case. Although MDI scores show a greater gain than PDI scores, the overall mean MDI score, although now marginally within the normal range, is still about 10 points below the overall mean PDI score, as compared to a 14-point difference on the pretest.

Explanations of Gains

The question arises if perhaps the positive gains we have found between first and second administrations of the BSID can be a function of some extraneous factors and are not really indicative of the treatment intervention effects of the PCC programs. We must ask:

1. Can the gains be due to chance?

When two means are significantly different at the $p < .01$ level there is less than one chance in 100 that a difference as large as that obtained is due to chance. Many of our group means and our MDI overall mean were significant at the .01 level or less. Therefore, it is very unlikely that they represent randomly occurring differences rather than systematic results. As previously stated, all groups show mean gains in MDI and PDI scores from first to second administration of the BSID. It is extremely unlikely that these consistent positive gains are due to random error variation.

2. Can the gains be due to practice effects?

It may well be that the first administration of the test does affect the scores obtained on the MDI and PDI on second administration of the test. Practice in test-taking procedures and familiarity with the test items and with the examiner (who administered both the pretest and retest) may have had some effect on test-retest scores. However, a ten-month interval occurred between test and retest. Since item selection by the examiner is based on the child's chronological age level, it is unlikely that the first test administration for each child included exposure to the more difficult items included in the second test administration.

At the second administration of the test, the child encountered many more difficult items since he was expected to be able to pass such items because of his gains in age and development. For example, a score of 100 on the MDI by a child at 14 months and a score of 100 by the same child at 24 months both indicate that the child scores at the 50th percentile of his age distribution. However, the similar scores do not mean the child passes the same number of items. The child must be able to pass many more difficult items on retest that he did ten months earlier on the pretest in order to earn the same standard score.

3. Can the gains be due to a regression toward the mean?

The mean scores of the children in the PCC centers on first administration of the scales were well below those of the standardization sample for the BSID. Retest scores on the MDI were also somewhat below those of the national normative sample used in the standardization of the scales. Thus, in general, our sample of PCC children scored lower on the test than children in the national sample.

A regression phenomenon reflects a trend toward mean or middle values. When scores from one administration of a psychometric test have low values as compared with the general distribution of test scores, these scores are characteristic of two kinds of persons: those who are typically low and can be expected to stay low on the retest and those who are not generally at the lower extreme, but have moderate scores and can be expected to move back toward the average of the entire distribution. If an entire distribution of scores is examined, some will go up and some go down, and the positive and negative deviations will cancel each other out. However, if only an extreme group is measured (like our low-scoring PCC sample) the only possible movement is toward the center or mean value. If this occurs on second testing, the variability will often appear to decrease.

What the regression phenomenon does is give an illusion of decreasing variability for a total group based on extreme cases. If a regression to the mean is occurring, variability of retest should appear less than that of the first test. Our data show only an insignificant decrease in variability of our sample scores from first to second testing. (MDI: standard deviation pretest = 17.3, standard deviation retest = 16.3; PDI: standard deviation pretest = 16.0, standard deviation retest = 15.5.)

Another indication of a regression to the mean is a greater gain in scores for children who are farther from the mean of the normative sample on the pretest than for those closer to the mean. Despite the small decrease in the variability of scores from first to second test administration, there appears to be a definite trend for the scores farthest from the mean (100) to show the greatest gain. (See Tables 34 and 35.) These scores are almost always below rather than above the mean, since the majority of the PCC scores were very low on the pretest.

Thus, a regression to the mean definitely appears to be affecting our data. The question is: Is there any gain in scores above gain that is due to the regression effect?

If only a regression effect is operating, scores equally spaced on each side of the mean should show approximately equal movement (although in opposite directions). If we compared the few scores above the mean with scores in similar intervals below the mean (through a rearrangement of the data presented in Tables 34 and 35), we find that for the MDI the mean gain score in the interval 101 to 110 is approximately equal to the mean score in the interval 90 to 99 (-1.0 versus 1.1). Since only one MDI score is available for the interval 111 to 120, a comparison with the 80-89 interval is not possible. For PDI scores, the 101 to 110 and 90-99 intervals show approximately equal absolute gains (-7.5 versus 7.1). However, the 80-89 interval shows a 15.4 mean gain (N=10) while the 111 to 120 interval shows only a -1.0 mean gain (N=3). This may be an indication of a greater positive gain in PDI scores than the gain due only to a regression effect. It is not possible to assess exactly how much of overall significant gain in MDI and PDI scores is due to a regression effect. However, data in Tables 34 and 35 certainly indicate that a sizable portion (if not all) of the gain is due to the regression-to-the-mean effect.

How does this affect the following analyses of age, sex, ethnic group and center effects? When significantly higher mean gains occur for the groups that have lowest means on the pretest (as in the case of the PCC children on MDI), we must assume these higher gains are merely an artifact of the regression to the mean. If, on the other hand, we find significantly different gain scores for groups that did not differ significantly on the pretest, then we can assume these differences are not due to a regression effect. Even if the seemingly positive overall gains are attributable to the regression phenomenon, the following analyses of group differences are still valid as long as the groups did not differ significantly on the pretest.

TABLE 34

Number of Children with Certain MDI Gains as a Function of Scores on Pretest

	Pretest Scores								
ain Scores	49 or less	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120 or more
21 or less					2		1		
16 to -20								1	
11 to -15					1	2			
6 to -10				1	1	1	2		
1 to - 5		1	2	2	2	3			
0 to 4			2	1	2	1	2	1	1
5 to 9	1		2	2	3	3			
10 to 14		1	1	3	4	3			
15 to 19	1			3					
20 to 24		1	2	3					
25 to 29		1	2	1					
30 to 34			1	1					
5 to 39	1			1	1				
0 or more	1	2	1		1				
N	4	6	13	18	17	13	5	2	1
X̄ Gain	26.8	28.8	15.8	13.6	4.1	1.1	-1.8	-7.0	+9.0

TABLE 35

Number of Children with Certain PDI Gains as a Function of Scores on Pretest

	Pretest Scores								
Gain Scores	49 or less	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120 or more
-21 or less							1	1	1
-16 to -20					1	1	1	2	
-11 to -15						3	2		
- 6 to -10						3	2	1	
- 1 to - 5				1	1	1	3	1	
0 to 4			1	2	1	2	3	2	
5 to 9				1	1	3	2	1	
10 to 14				1	1	3	2	1	
15 to 19			1	2		1	1		
20 to 24				1	1	2	1		
25 to 29			1		2	2			
30 to 34					1	2			
35 to 39			1	1					
40 or more	1	1	2	1	1				
N	1	1	6	10	10	23	18	9	1
$\bar{X}$ Gain	48.0	41.0	29.0	15.8	15.4	7.1	-3.8	-6.0	-26.0

As stated in Appendix E, larger proportions of boys than girls fell below the normal range on both MDI and PDI scores on the first administration of the BSID. When children who were not retested are eliminated from analysis, this finding of lower scores of boys on the first testing is still valid. As can be seen in Table 36, retest scores show this same difference between boys and girls (i.e., girls still score significantly higher on both scales). Although more boys and girls now score within the normal range, the interventions of the centers did not reduce the gap between the two-score distribution.

TABLE 36

Pretest and Retest Scores by Sex

		N	Mean Pretest	Mean Retest	T Test of Difference
MDI:	Boys	43	73.3	84.9	4.34*
	Girls	36	81.2	92.1	3.41*
PDI:	Boys	43	88.2	96.0	2.44*
	Girls	36	94.8	101.2	3.56*

* p < .01

It should be noted that on each scale, both boys and girls show highly significant gains from first to second testings, and the mean gains are approximately the same on both scales for boys and girls.

Age Differences

On the pretest, there appeared a steady drop in developmental ability with age on both the mental and motor scales, although the decline was more pronounced on the mental scale. This drop in developmental ability provides a gross cross-sectional analysis of what may be happening in impoverished families. It is hypothesized that age differences were responsible for the lower scores of boys than of girls since boys in the sample are almost three months older on the average than the girls. Since all children were retested after approximately equal intervals, it would be possible that sex again interacts with age. However, on the retest we do not find a steady drop in ability with age. This hypothesized age-ability relationship cannot explain sex differences on the retest.

As can be seen in Tables 37 and 38, this decline in developmental level with age is somewhat counteracted by the experience of the children between first and second test administration. On the retest a curvilinear relationship appears present: Scores on both the MDI and PDI do decline initially with age; then at the ages of 29 to 36 months scores on both scales again increase. Lowest MDI scores occur on the retest in the medium age ranges of 21 to 28 months. On the PDI, lowest scores are in the 17 to 28 month age range.

TABLE 37

MDI Scores on the Retest by Age

Age	N	MDI Scores							
		89 or Below		90-109		110 or More			Standard Deviation
		N	%	N	%	N	%	Mean	
9-12 mo.	4	1	25	2	50	1	25	104.2	16.4
13-16 mo.	12	4	33	8	67	0	0	94.3	9.4
17-20 mo.	15	7	47	8	53	0	0	87.8	13.8
21-24 mo.	15	11	73	3	20	1	7	80.5	15.7
25-28 mo.	14	8	56	6	44	0	0	81.0	16.0
29-32 mo.	12	6	50	6	50	0	0	87.0	13.9
33-36 mo.	7	3	43	1	14	3	43	101.1	18.6
Total	79	40		34		5		87.7	

TABLE 38

PDI Scores on the Retest by Age

Age	N	PDI Scores							
		89 or Below		90-109		110 or More			Standard Deviation
		N	%	N	%	N	%	Mean	
9-12 mo.	4	1	25	1	25	2	50	107.8	16.3
13-16 mo.	12	2	16	6	50	4	33	105.7	13.2
17-20 mo.	15	6	40	9	60	0	0	92.2	9.3
21-24 mo.	15	5	33	8	53	2	13	94.4	11.0
25-28 mo.	14	8	56	4	29	2	14	92.7	17.6
29-32 mo.	12	2	16	3	25	7	58	101.7	18.3
33-36 mo.	7	2	29	2	29	3	43	108.4	13.9
Total	79	26		33		20		98.4	

Ethnic-Group Differences

As can be seen in Table 39, at the time of the first administration of the BSID there were no significant score differences on the MDI or PDI among ethnic groups.

TABLE 39

MDI and PDI Mean Scores According to Ethnic Group

Ethnicity		N	Pretest Mean	Retest Mean	T Test of Difference
MDI:	Negro	32	79.2	90.3	3.56*
	Hispano	21	74.6	86.6	2.79*
	Anglo	26	78.8	86.6	2.84*
PDI:	Negro	32	90.3	100.6	3.06*
	Hispano	21	92.8	97.2	1.02
	Anglo	26	91.1	96.8	1.39

* $p < .01$

Gain scores from first to second administration suggest a lower gain for Anglos on the MDI than for the other two ethnic groups and a higher gain for Blacks on the PDI than for the other groups. While the significantly lower Anglo gain on the MDI cannot be explained, the significantly higher Black gain on the PDI concurs with the finding that Blacks show a slight motor scale superiority. While in past studies this psychomotor superiority of Blacks has been revealed only at the ages of 3 to 14 months, in our sample no motor differences between Blacks and other ethnic groups appear at time of first administration of the BSID when the mean age of the children in the sample was 14 months, 6 days for boys and 11 months, 18 days for girls. However, on the second administration of the test, when the children were approximately 10 months older (boys' mean age = 24 months, 6 days; girls' mean age = 19 months, 12 days), a small but insignificant motor superiority of Blacks does appear to be present. These children's impoverished backgrounds may not have provided proper sensory-motor stimulation for such a developmental gain to occur. However, the intervention of the PCC programs may have, in part, allowed such motor superiority to present itself at a later chronological age through provision of suitable motor stimuli to these target children. However, the Black children's pronounced gain in motor ability at a later age than previously reported may be a reflection of the generally low developmental level of the children in our sample on the motor as well as the mental scale. Since they were at a lower developmental level to begin with, they may show the expected superiority at a later age in their development.

The lower gain of Anglos on the MDI is puzzling. Although the interaction of ethnic group with treatment program is a possibility, the predominantly Anglo centers generally had moderate gain scores, rather than falling at the extremes on either side.

Differences Among the Centers

Table 40 presents mean pretest and retest MDI and PDI scores for each of the six PCC's for which Bayley test scores are available.

TABLE 40

MDI and PDI Scores by Center

Center	N	MDI			PDI		
		Pretest Mean	Retest Mean	T Test	Pretest Mean	Retest Mean	T Test
05	15	75.9	80.5	1.09	94.5	95.6	0.19
29	13	76.0	86.1	2.24*	87.7	96.9	1.52
01	13	85.3	91.5	1.56	94.3	106.8	2.31*
25	14	74.0	89.1	4.02**	88.6	97.6	1.46
30	11	73.4	94.2	3.34**	92.2	95.4	0.56
16	13	82.1	89.2	1.42	92.6	98.2	1.50

* $p < .025$

** $p < .01$

A fairly wide range of gain scores on both scales occurs. MDI mean gain scores range from 4.6 (an insignificant gain that could be due to chance or a regression toward the mean) to 20.7 (a highly significant gain that one would find by chance less than one time in 100). The PDI mean gain scores range from 1.1 (an insignificant gain) to 12.5 (a significant gain). It must be remembered that insignificant gains at some centers may be due to the small N's involved.

Centers where children show significant gains on MDI scores are, in order of size of gain, Centers 25, 30, and 29. The only center showing a significant gain on PDI score is Center 01, a center with a 65 percent Black population. Although this motor gain could be more an effect of ethnic group than of the center itself, the few Anglo children at this center show a motor gain comparable to that of the Black children. Black children at other centers do not show as great a gain as this center's Black children. Generally, gain seems to be independent of ethnic group composition of the centers (i.e., there are generally no differences among gains of various ethnic groups within centers). When differences do occur there is usually a very small N in one or two groups. For example, Center 25 shows higher scores for Negro than for Anglo children, but N Anglo children is only 4. However, centers with higher gains may be heavily weighted toward one ethnic group.

The higher gains on MDI and PDI of some centers do not appear to be directly related to the type of program available to youngsters at the various centers. When the six centers are categorized according to the amount of structure present in their programs and the type of care provided (day care, home visit or casework) the following pattern emerges.

TABLE 41

Amount of Structure and Type of Program Offered by Centers in BSID Sample

Center	Type of Program	
25	Structured	Home care
01	Structured	Home and day care
30	Unstructured	Day care
29	Unstructured	Activity
05	Unstructured	Activity
16	Casework	

The pattern of gain does not appear to relate to the amount of structure or to type of care provided. Even Center 16, which provided only casework and where most of the children were not seen by center personnel from first to second test administration, shows a moderate improvement in test scores. The centers with the most structured programs do show the most highly significant gains (Centers 25 on MDI and Center 01 on PDI). Center 25, the one with the most significant MDI gain, was actually the only center that provided a highly structured program devised by experts in the field of child development.

Actually, the centers with the lowest MDI scores on the pretest also show the greatest gains on scores from first to second test. A regression-to-the-mean effect may be responsible for what appear to be significant differences between centers in the amount of gain scores on the MDI. However, on the PDI, Center 01 which had a high score on first test administration shows the most gain, although within Center 01 the lowest pretest scores still show the most gain.

Possible Interactions

It is extremely difficult to separate the effects of different variables because in many cases the variables of age, center, and ethnic groups are confounded. These variables are correlated with each other and to some extent occur together. It is sometimes impossible to determine which of these variables relate to a change in scores from first to second test administration. For instance, since girls are, on the average, three months younger than boys, the higher BSID scores for girls on first test administration may be related to age level rather than to sex. Centers and ethnic group are also interrelated. The center that shows the largest PDI gain also has a 65 percent Negro population. In order to determine whether gain scores relate to sex, ethnicity, age or center it would have been necessary to select equal proportions of children of different ages and ethnic groups within each center. However, such careful selection was impossible during this evaluation.

Comparison With Other Test Samples

The Collaborative Perinatal Research Project Sample[1]

Since infants in the PCC sample come from disadvantaged families with a generally low socioeconomic status, infants in the Perinatal sample from families with socioeconomic indices of 40 or below (N = 16, 277) were selected for comparison with the PCC infants. The SEI (Socioeconomic Index) devised by Myrianthopoulos and French (1968)[2] assesses the socioeconomic status of subjects through a multidimensional set of rankings of paternal education, occupation, and family income. There does seem to be a borderline relationship between SEI and BSID scores, particularly motor scores. The Perinatal sample consisted of infants approximately eight months of age. Since our data show that BSID scores on PCC children may vary with age, it was necessary to compare infants of the same age with the Perinatal sample. Since only seven eight-month-olds were tested in our sample, it is impossible to draw any generalizations. However, as seen in Table 42, all White males and White females in the PCC sample score below the mean Perinatal scores on the MDI. On the PDI all four PCC males score above the Perinatal PDI mean scores. Data reported by Dr. Ira Gordon in a personal communication (July 1969) revealed information about another sample of children whose MDI and PDI scores were higher than those of children in the PCC sample. Thus, these comparisons lead us to conclude that the PCC sample's scores are depressed on the MDI as compared with scores of other samples, while our PCC sample may score either higher or lower than other samples on the PDI.

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[1] See earlier discussion in this chapter of "The Collaborative Study...."

[2] N.C. Myrianthopoulos and Katherine S. French, "An Application of the U.S. Bureau of the Census Socioeconomic Index to a Large Diversified Sample," Social Science and Medicine (1968) vol. 2, pp. 283-299.

TABLE 42

Mean MDI and PDI Scores of PCC and Perinatal Samples

	MDI			PDI		
	Peri	PCC	N of PCC	Peri	PCC	N of PCC
White Male	85	78(73) (78) (76)	3	86	107(104) (106) (110)	3
White Female	86	63(78) (78) (34)	3	87	76(101) (74) (54)	3
Negro Male	82	84	1	85	104	1

Comparison with Schaefer Findings

A number of observers, including Schaefer[1] and Gordon, have noted a decline in Bayley scores of poor children between the ages of 14 and 21 months, a finding that has been variously interpreted as an artifact of the test, as an indicator of developmental crisis, as a harbinger of the effects of deprivation, and in other ways. In his Message to Congress of March 3, 1970, President Nixon, citing the Schaefer study, suggests that this decline might "be forestalled by skillful tutoring ...."

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[1] Earl S. Schaefer, "A Home Tutoring Program," Children, vol. 16, no. 2 (March-April, 1969), pp. 59-61.

With these observations in mind, we plotted MDI and PDI scores by age, separately for boys and girls, and for the pretest and retest. We separated the sexes because of earlier studies suggesting in part that girls are more refractory to environmental effects than are boys.[1]

In the following discussion the reader is reminded that we are dealing with small numbers: pretest data represent a total of 61 boys and 48 girls; the retest data represent 44 boys and 35 girls. The number of children at any given age is very small indeed. In the graphs that follow we have plotted median scores.

Findings on Boys--Mental Development Scores. Both the pretest and retest data support the observation of a score "dip" in the second year. In both cases the scores promptly rise, and then start down again. (See Graphs 5 and 6.) The retest data show the dip starting and ending about three months later than the pretest data; the pretest data agree with Schaefer's observation of a drop between 14 and 21 months of age.

Findings on Boys--Psychomotor Development Scores. Our data do not as neatly confirm other observations. While the pretest PDI scores do dip between 14 and 21 months, an examination of Graph 7 will indicate that this is simply another "step" in a declining series of scores. Smoothing the curve would eliminate that dip. The retest curve is quite different. Starting at a higher score level, it drops until 25 months, climbs rapidly until 32 months, and then drops back to its 25-month level. This is the same age period in which we observed a dip in boys' weights, and both the weight drop and psychomotor score spurt may reflect a period of increased activity on the part of PCC boys. Why these should occur at that point has not been determined, but these phenomena may simply reflect a peculiarity of our sample.

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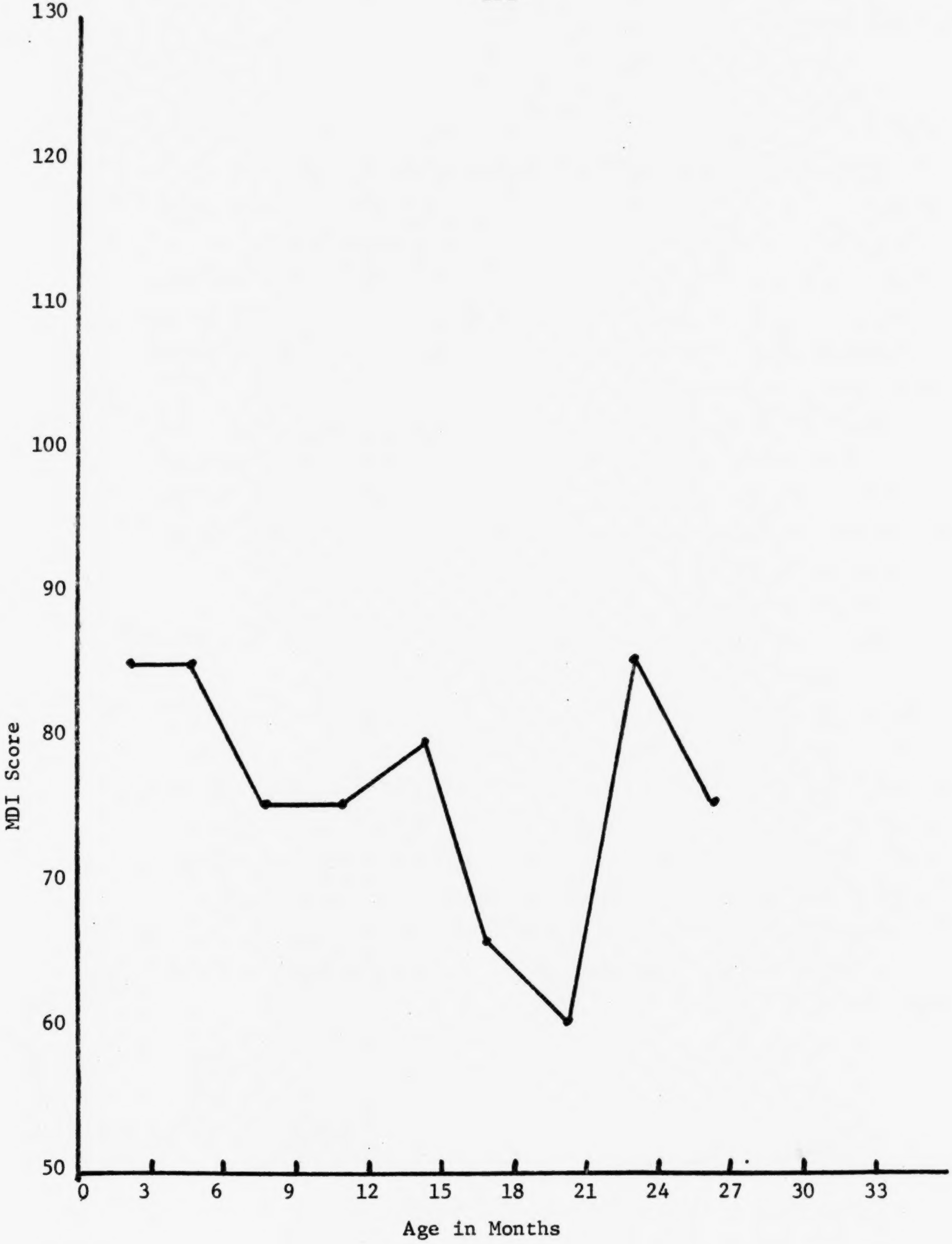
[1] Nancy Bayley, "Behavioral Correlates of Mental Growth: Birth to Thirty-six Years," American Psychologist, vol. 23, no. 1 (January 1968), pp. 1-17.

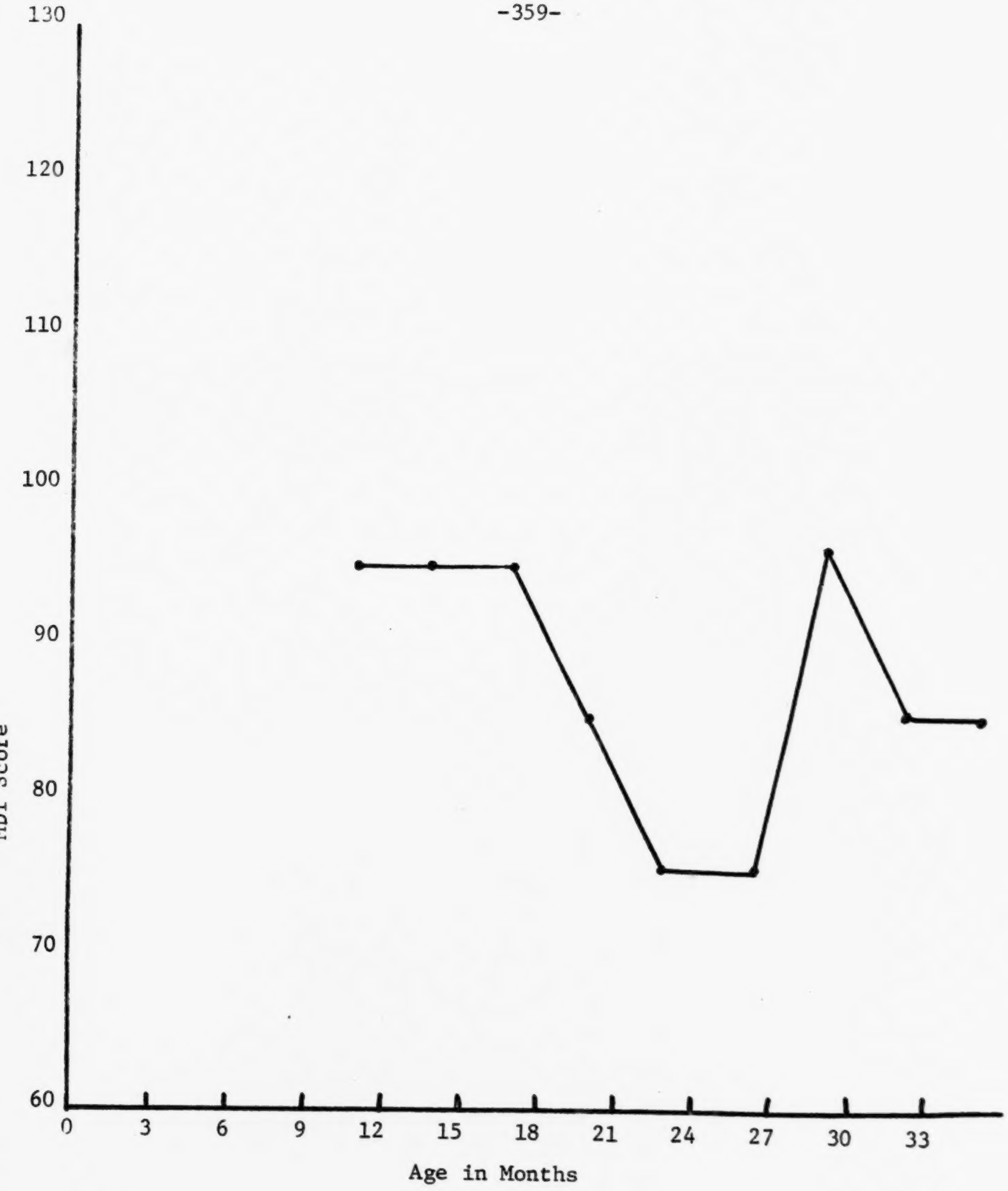
Findings on Girls--Mental Development Scores. None of our data on girls support the observation of a 14-21 month dip. The pretest data reflect an almost unrelieved decline in score levels for the first two years. The retest data are completely erratic (see Graphs 9 and 10). A dip does appear between 19 and 22 months, but so does an apparent spurt from 27 to 31 months. We are inclined to regard this finding as a sampling phenomenon.

Findings on Girls--Psychomotor Development Scores. Like their mental development scores, the girls' PDI scores show a continual decline during the second year after a series well inside the normal range during the first year. The girls retest PDI data show the same spurt at the thirty-first month as did their MDI scores. (See Graphs 11 and 12.)

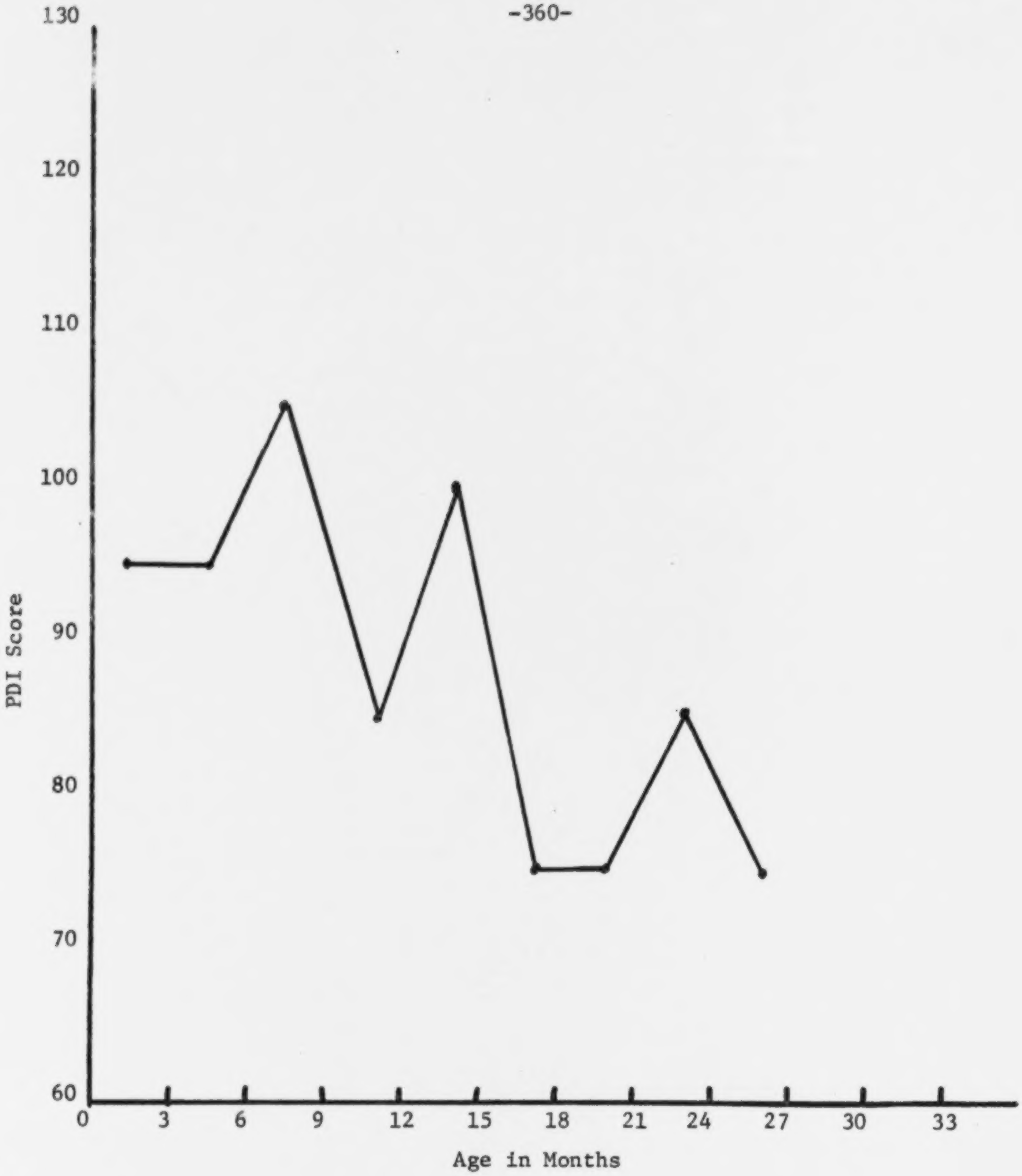
While, on the whole, a cross-sectional examination of our data displays a continuing decline in scores with increases in age, with some spurts upward in the retest data, our findings do not confirm other observations of a drop in scores during the period of 14-21 months. Our boys' Mental Development scores do fit the observation on pretest, and then their scores rise for several months and drop again. In the retest data this "trough" appears three months later. The fact that it does not appear in the boys' PDI data, nor in the distribution of girls' scores suggests that this is not an artifact of the Bayley Scales' standardization. However, we have no other explanation to offer.



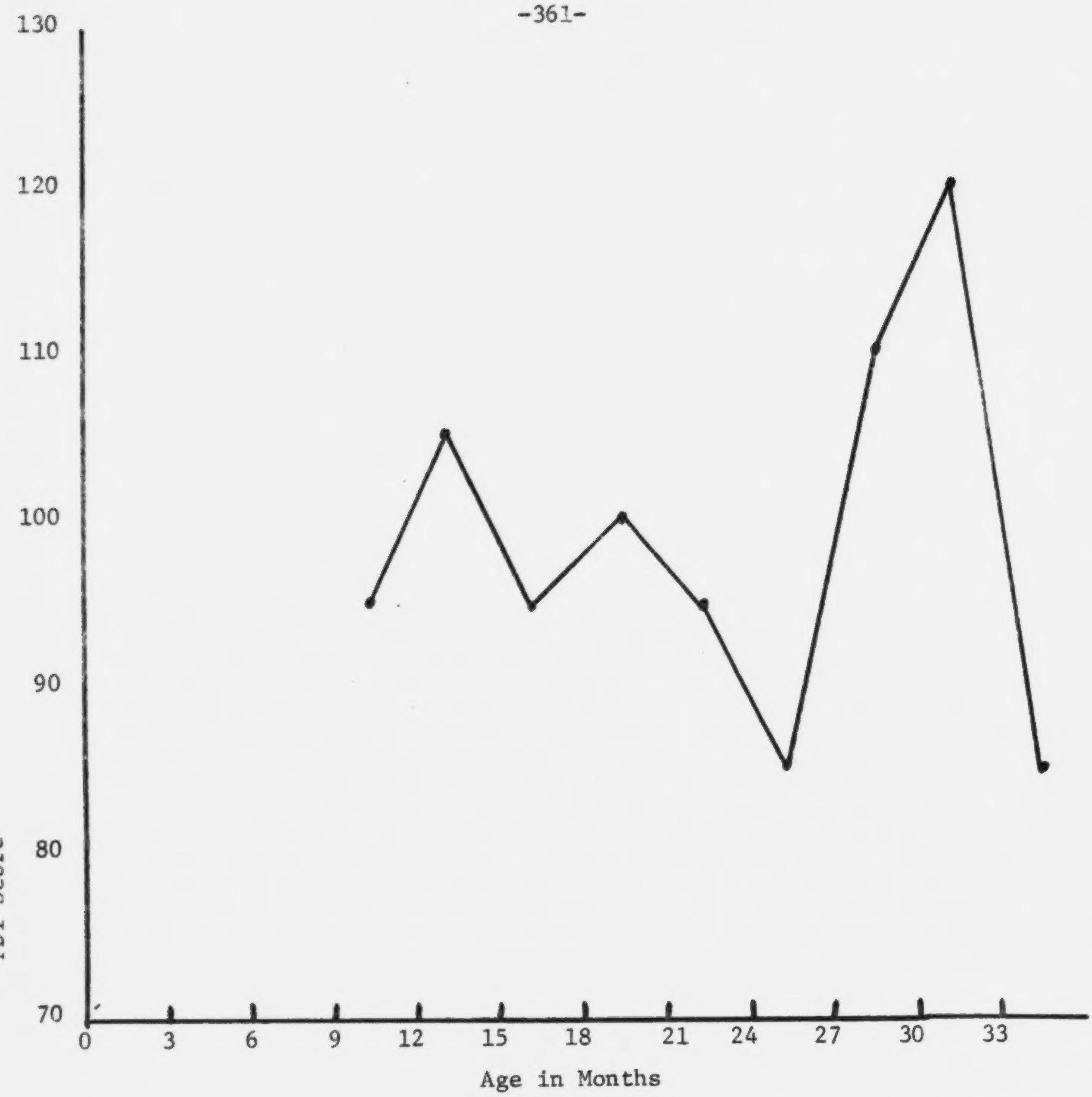
GRAPH 5: MDI Pretest--Boys



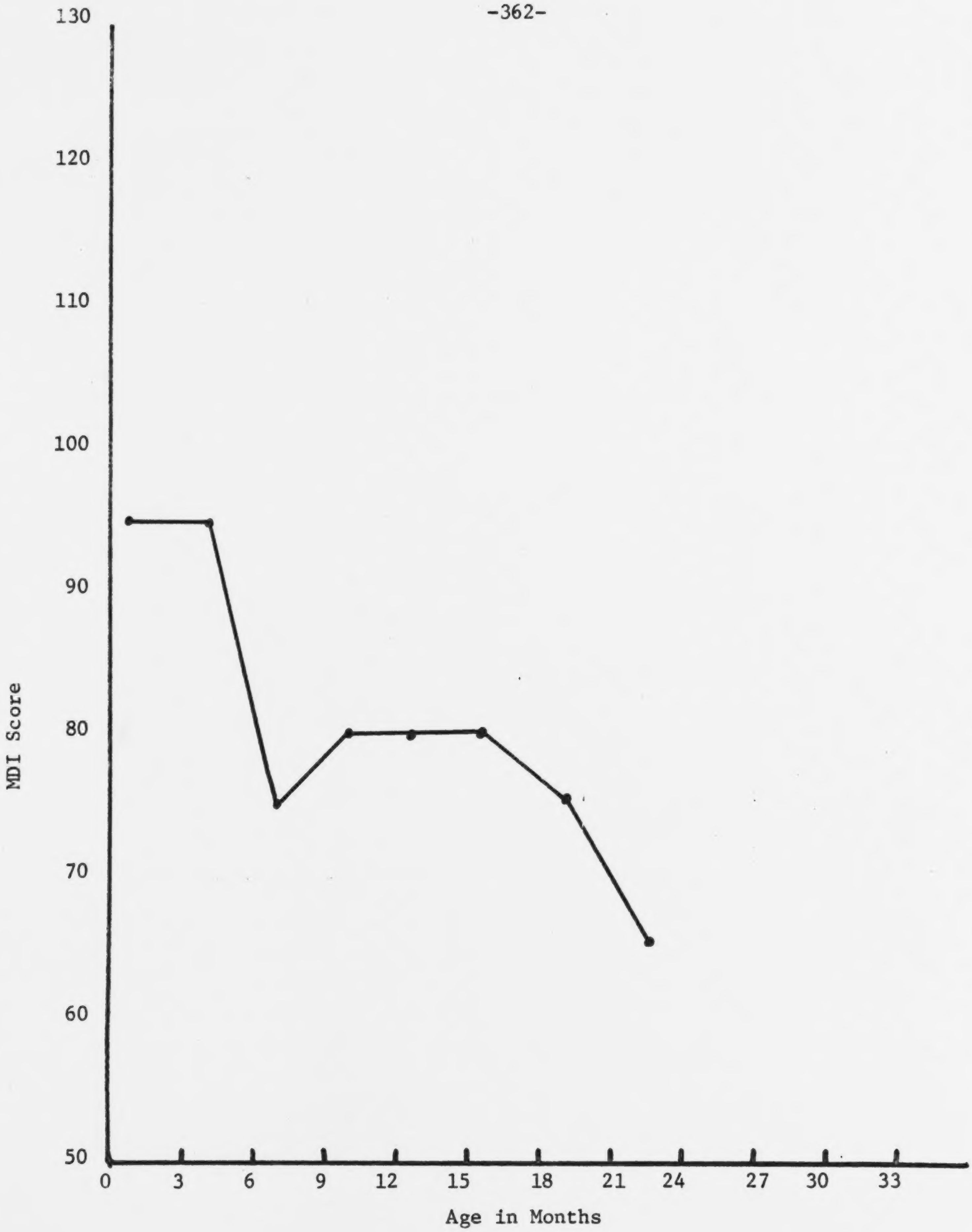
GRAPH 6: MDI Retest--Boys



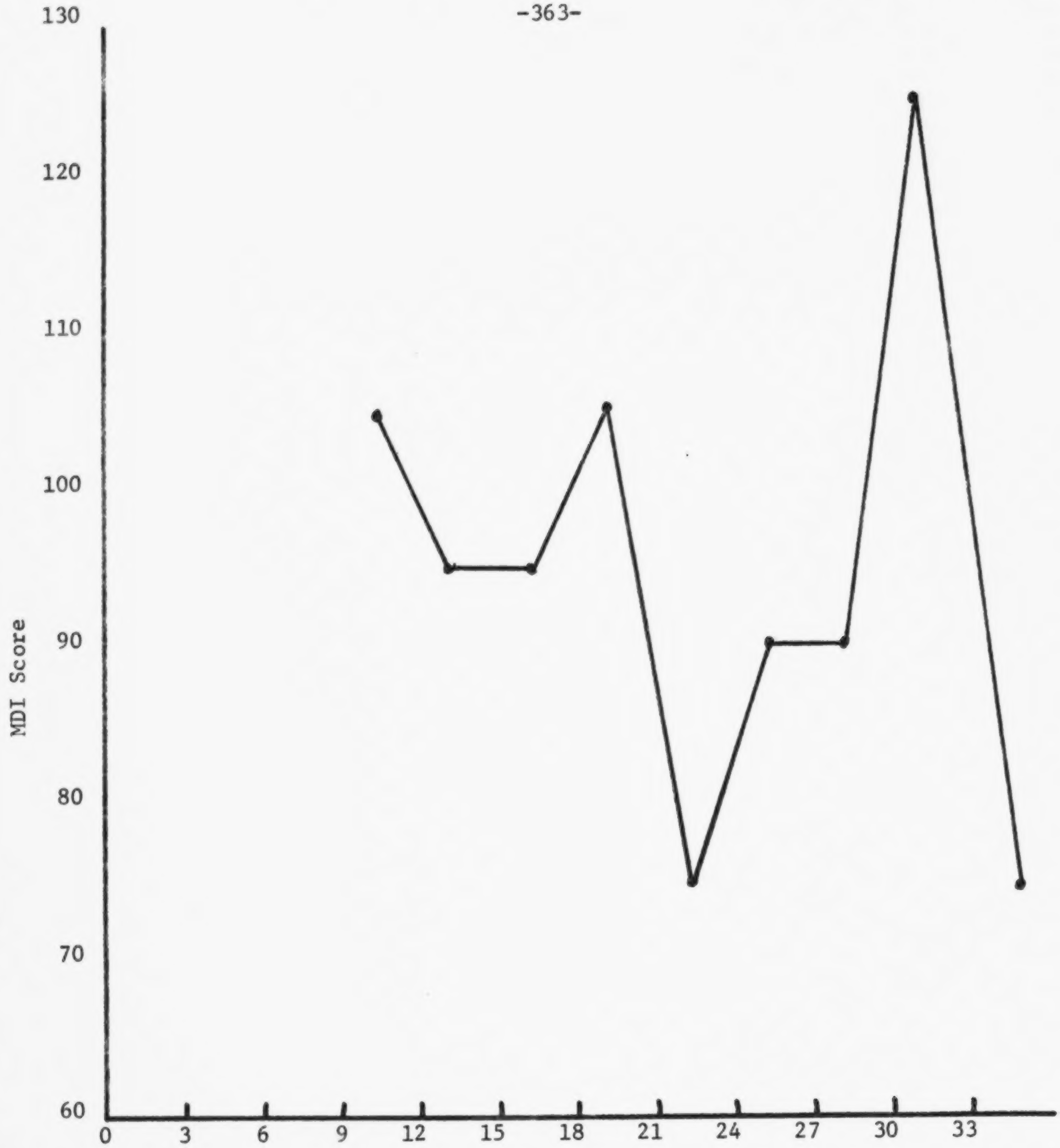
GRAPH 7: PDI Pretest--Boys



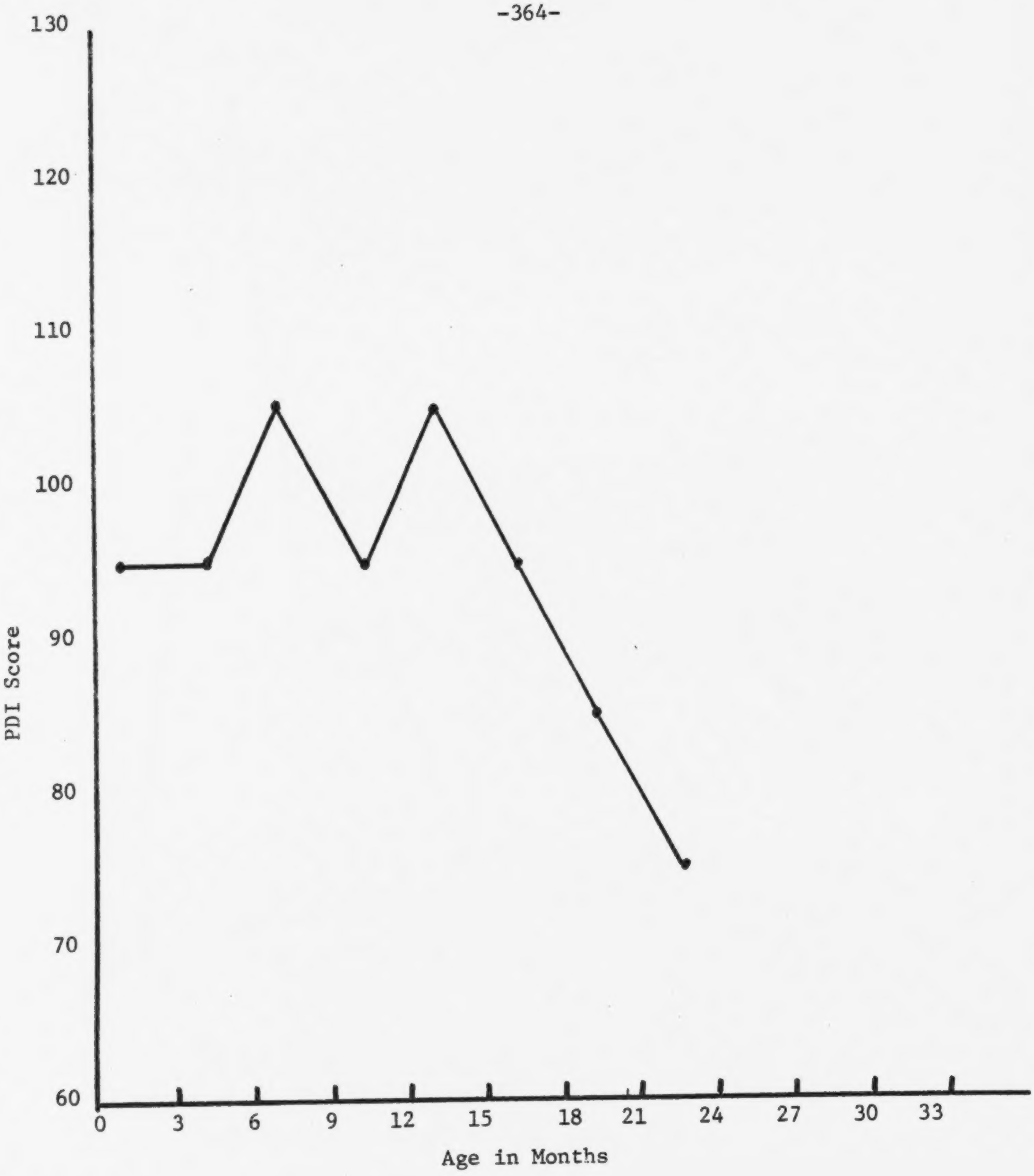
GRAPH 8: PDI Retest--Boys



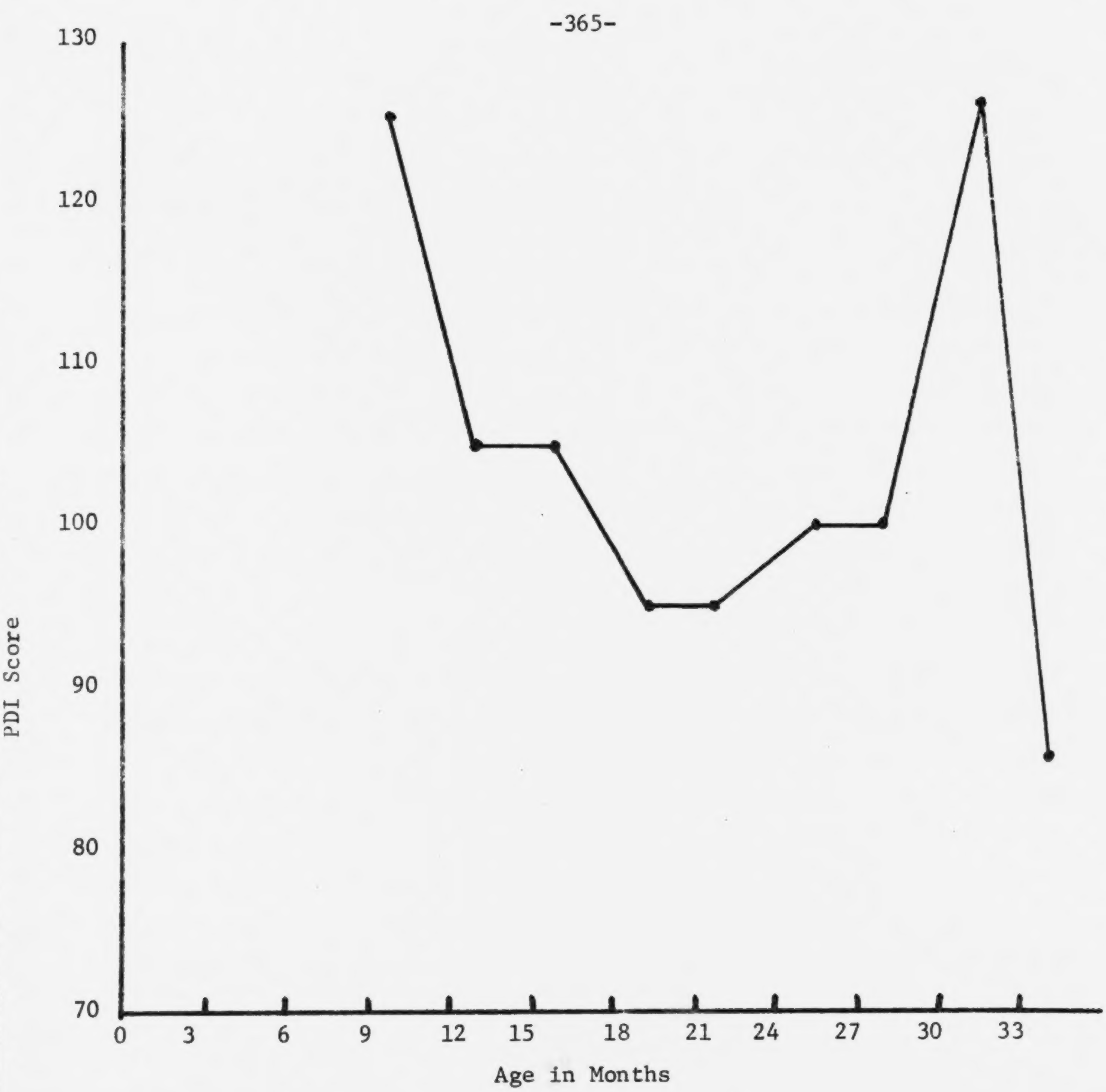
GRAPH 9 : MDI Pretest--Girls



GRAPH 10: MDI Retest--Girls



GRAPH 11: PDI Pretest--Girls



GRAPH 12; PDI Retest--Girls

OTHER IMPACTS

Given the fact that the centers have, for the most part, selected the poorest of families to work with and have often been placed in communities with the sparsest service networks, the fact that almost all of them exist and serve families is in itself a major accomplishment. That they are functioning and are as diverse as they are means that the initial federal goal has been reached--at least in part. The test data cited above suggest that they may be fulfilling a "later" goal of positively affecting development.

It is too early and beyond the scope of this study to assess impacts of this program, either on the communities in which centers function or on the families they serve. However, some initial generalizations can be drawn from our observations. Twenty-seven of the programs seemed to us to have progressed to the point where some crude assessments of outcomes might be made, and our FRA's were asked to comment on these. The comments below are clinical observations--not fully documented but rather the impressions of our observers based on visits to centers and homes and on discussions with staffs and parents.

In the Epilogue of this report Dr. Lois B. Murphy describes and analyzes at considerable length what she believes are some of the achievements and impacts of the program.

Community Effects

At least six of the centers have achieved high visibility in their communities. Some of these are in major cities where such visibility is difficult. One, indeed, has received considerable national press coverage. This visibility is a result of considerable staff effort and has stimulated local interest in establishing additional Parent-Child Centers. In one large city the PCC was apparently the first interdisciplinary program for children. In four southern communities the PCC's are public models of racial integration--and these are "successful" models in terms of the genuiness of the integration.

Several PCC's have done outstanding jobs in coordinating resources, achieving cooperation between agencies that had never really worked together before.

PCC's in six cities have had visible effects on the operations of traditional agencies--bringing about changes in the public school system, in the operations of well-baby clinics, and in welfare departments, or contributing to the development of new community programs in nutrition and food distribution and in community health.

One PCC got the price of school lunches reduced; another got a publicly supported adult-literacy program established; still another got window-guard rails installed in a public housing project. Another PCC brought about a complete change in the clinic policies and appearance of a medical school. This same PCC negotiated policy changes with both the telephone and gas companies to make them more humane in dealing with the problem of late payments. And several, in this short period, have established themselves as the first stop when child-related crises arise--much in the style of the settlement houses of an earlier time.

These are community impacts of Parent-Child Centers--though the strength, the stability, and the contagion of these changes will need to be assessed at a later time.

Effects on Families

A wide variety of changes in the parents was reported by staff. Chief among these were related to everyday behaviors: housekeeping standards improved, along with the mothers' personal grooming and dress in many centers. Increased sociability and community involvement were frequently noticed. Six of our field research associates reported director's feelings that the mothers' self-concept had improved and that their aspiration levels had risen. Five observers reported better relationships at home, but in two centers the mothers' increased independence and self-confidence produced family strife. Several centers have had notable success in improving the availability of food and housing. Many have helped parents increase their use of community resources and have improved their health and health care.

Field research staff reports that a number of centers have been able to increase the employment opportunities of the families, and these reports are confirmed by the data on the Termination of Service Reports.[1] Since the programs have been operating such a short time, these reports do not yet fully reflect the impact of the program, but it can be expected that this will increase in time. Even though the 608 families terminated have been served only an average of 3.8 months, some outcomes are already apparent, particularly in the area of employment. While there was an increase of only one percent in the employment of the fathers, there was a 13 percent increase in employment reported for the mothers. At the time of termination from the PCC, 17 percent of the mothers who had previously been unemployed had found jobs, while only three percent of the mothers who had been employed at the time of acceptance were unemployed at the time of termination. It can be anticipated that this impact may increase with longer participation in the PCC program and that later reports will show an even higher rate of new-found employment.

Effects on Children

Most often mentioned was the improved health and developmental level of PCC children. Parents report better relations with their children, and the children themselves often appear cleaner, neater, more relaxed, friendlier, more sociable and self-confident than they were earlier in the program. In many cases the children are eating better, and are more verbal and less docile since joining their PCC. With few exceptions, our observers report the children as having become more cheerful, energetic, and friendlier since their enrollment in these programs.

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[1] See Appendix B for the complete information on reasons for termination, length of time enrolled, and other outcomes.

To be sure, these staff reports may simply be self-congratulatory defenses and expressions of enthusiasm for their work. Children ordinarily grow in verbalization, for example, between the ages of one and three, so that such a report may be merely a statement that nature has taken its course.

Effects on Staff

Certain of the usual effects of programs for the poor have been noted among the staff of the Parent-Child Centers. These include increased intercultural and interclass appreciation as well as conflict. When the line between professional and nonprofessional and the distinction between "staff" and "client" disappear there is an increased opportunity for conflict as well as understanding. Where conflict has been high, so has staff turnover, but where the conflict has been well-handled, even if it is high, both the professional and the nonprofessional staffs have increased their understanding of variations in culture, life style, and problems of bringing about social change in a complex society.

Almost unanimously our field research staff has reported with one kind of phrase or another that "the greatest impact of this program has been on those parents and other low-income people employed as staff of the PCC."

Despite the many questions these observers have raised about the quantity and sometimes even the quality of the services delivered by some of the indigenous staff, there is no doubt that when these indigenous staff members remain on the job for any length of time, they shown great change, growth, and rehabilitation. The words of one of our field research associates in describing the greater impact on those parents employed as staff will be repeated here again: "In short, people who work in America feel better about themselves than people who don't."

SUMMARY

The Bayley Infant Development Scales, a broad-gauged and well-standardized method of comparing the development of infants and toddlers, was administered to 109 infants in six Parent-Child Centers. Forty weeks later the scales were readministered to the 79 of these children who were available. The children came from the three major ethnic groups, from different parts of the country, from rural and urban centers, and were approximately evenly divided by sex.

On initial examination these children scored, on the average, considerably below the norms for their age. On reexamination all groups showed positive gains in both mental and motor scores. They maintained consistently higher scores in motor ability than in mental development, although there were greater gains in the Mental Development scores. Because of the size and nature of the sample a good part of these gains may be statistical artifacts--more apparent than real--and larger studies would need to be undertaken before any relationship between PCC programs and test gains could be more clearly demonstrated.

On the whole, girls scored higher than boys on both the initial and the follow-up examinations.

The steady drop in test scores with age found on the initial testing was not found on retest, where scores started to increase after 29 months of age.

Aside from a slight motor ability superiority among Black children, no ethnic differences were found in the examination data.

Children in the centers with the most structured children's programs achieved the largest gains in examination scores; those enrolled in the least structured programs achieved smaller gains.

Comparison with other samples of low-income infants indicates that, on the whole, the PCC children had lower Mental Development scores than other groups of impoverished children.

Because of its usefulness in identifying the needs of individual children and of assessing program effects, it is recommended that independent developmental examinations of focal children be conducted as a regular part of the PCC program. While too early to measure impacts of this program on either the children, the families, or the communities in which they live, qualitative indicators suggest that positive impacts are developing--and that some centers are accomplishing positive changes in their clients and in the other agencies in their communities.

The nature of this project is such that quantitative data concerning program impacts are limited. What qualitative data have been collected, however, indicate that, as a whole, PCC's have influenced their environment (particularly selected institutions related to the poor), the parents and children served, and particularly the indigenous poor employed as staff members. The following chapter provides some information about the costs associated with the attainments.

CHAPTER XII

COST ANALYSIS

INTRODUCTION

As discussed elsewhere in this report, this project is concerned primarily with a description and analysis of the inputs (and services) of the PCC program as opposed to an analysis of the results or outcomes of the program. Since there are no outcome measures for the PCC, it is not yet possible to analyze the relationships between program costs and effectiveness, or program-generated benefits; therefore, this project has focused on methods for collecting cost data and methods of cost analysis as data become available.

There are several factors regarding the PCC program that must be borne in mind when interpreting cost data for the program and to understand the difficulties of performing cost-effectiveness or cost-benefit analyses at this time. First, the individual PCC programs are often quite complex, or at least they often offer a comprehensive range of services. In fact, some PCC's are similar to CAA's in the scope if not the magnitude of services they offer. There is often considerable overlap between the program services of the PCC's and of other social service agencies.

Second, the multifarious nature of the PCC programs creates an enormous problem of defining their goals except in very vague terms. Because of the lack of goal definition by the programs, it is exceedingly difficult to measure progress toward goals and to determine whether resources are being wisely allocated to attain goals.

Third, the PCC program is not only an experimental or pilot program but is in a very early stage of development. Many of the individual centers had become fully operational only within the last year or less of this project. The centers have experienced various start-up and organizational problems that may render the first year or two of operations atypical of subsequent periods.

Moreover, programs have encountered problems because the art of child care, development, and education is in its own infancy.

Fourth, the cost data so far collected for the PCC program are fragmentary and of questionable validity. Therefore, only tentative findings and conclusions regarding program costs are warranted at this time.

The sections following discuss the cost analysis and data collection design for this project, tentative findings regarding program costs, and recommendations for analyzing and controlling program costs.

COST ANALYSIS AND DATA COLLECTION DESIGN

As part of its development of a national data reporting system for the PCC program, KAI developed a system for reporting income, expenditure, and staff activity levels. (The reporting forms are reproduced in Appendix F.) These reporting forms, discussed in further detail below, were designed to provide information for analyzing the relationships of costs and benefits of the PCC program.

FRAMEWORK FOR COST-BENEFIT ANALYSIS

Two types of analysis of the relationships between program costs and program benefits or effectiveness were considered in the design phase of this project. The first type of analysis is a comparison of program costs and program-generated benefits of the PCC and other child-care, development, and education programs such as those discussed in the chapter entitled "Programs for Children." This type of analysis would be of immense value to program planners, administrators, and legislators because it would provide a basis for comparing the net returns or benefits of alternative program designs. No attempt has been made, of course, to measure the benefits to society as a whole, to the government, or to individual clients of the PCC or of alternative programs. In fact, many of the potential benefits of infant programs are long-term in nature and would be observable only over a period of a number of years. Nevertheless, insights might be gained into the relative worth of alternative programs if costs could be compared with even incomplete indicators of benefits or assumed benefits of the various programs.

Comparison of PCC costs with the costs of other programs is not feasible, however, because of various differences in services offered, in outputs, and in the clientele served. The PCC's generally serve very disadvantaged families; many of the persons served by PCC's have severe deficits and adaptive problems. To the extent that other programs serve less disadvantaged families, interprogram cost comparisons may be biased against the PCC. Interprogram cost comparisons are also not valid because the PCC serves entire families, while the preexisting programs devote nearly all of their resources to infants and toddlers. Finally, the preexisting programs offer a limited scope of services (for example, focusing on child education), while PCC's often provide a wide variety of program services, including day care, breakfasts and lunches, and health services for both children and other family members, to name a few.

In view of these factors, attention was focused on developing an analytic procedure for specifying costs per unit of outcome in the PCC program. Although outcome measures are not available, such a procedure would be useful when a system for measuring outcomes is devised. Moreover, the collection of cost data for a cost-outcome analysis will result in the availability of cost data that might provide interim proximate measures of the relationships of costs to outcomes and of program efficiency.

The detailed procedure for analyzing program costs and outcomes and its underlying rationale are presented in Appendix F; therefore, it is summarized briefly here. Essentially, the PCC is viewed as a system having inputs (resources) devoted to program components that operate at certain activity levels. Costs are associated with activity levels of the components or functions of the program and so, too, are a series of outcomes or benefits of the program (which presumably could be zero).

The analytic procedure allows, if data are available, an analysis of the relationship between costs and outcomes associated with any component or function of the PCC based on the experiences of all individual PCC's having that particular component or function. The outcomes would generally be expressed in nonmonetary measures but in quantified terms. For example, it would be possible to express cost-outcome relationships in such terms as "degree of increase in child cognitive skill per dollar of cost," or "increased earning capacity of mother trainees per dollar of cost," etc. These types of cost-outcome measures provide a basis for comparing the costs of achieving specified outcomes in the PCC and in alternative programs whenever comparable data for the alternative programs are available.

It should be stressed that the feasibility of this procedure is not established. The procedure will not be feasible unless statistically significant patterns are discovered within the program of the relationships between costs and component activity levels and program outcomes. Also, the procedure will obviously not be feasible unless cost and outcome data are available.

It is recognized that outcome data are sketchy if they exist at all; therefore, attention was devoted to using interim or proximate measures of outcome. As explained in Appendix F, the proximate measures of outcome (such as numbers of persons served, number of contacts with clientele, or hours of service delivered by a center) are not very satisfactory measures of program outcomes. However, when such measures are compared with costs, reasons might be sought to explain any significant variations in these unit costs.

It was expected that cost data for the centers would be available so that descriptive cost profiles could be prepared for the individual centers and for the entire PCC program. The cost data would also provide a basis for intercenter cost comparisons, possibly allowing an analysis of the determinants of differences in unit costs of the PCC's. Unfortunately, most centers have not reported the requisite cost information.

COLLECTION AND ASSESSMENT OF COST DATA

The "PCC Director's Quarterly Program Accounts Report" form[1] provides for the collection of the requisite data for program cost analysis as outlined above and in Appendix F. Part One of the Program Accounts Report contains a summary of the volume of service activity for the program components of the PCC, and Part Two contains a detailed accounting by cost category of the costs incurred in operating each program component as well as administrative and overhead costs incurred.

All PCC directors were urged during 1969 to file Program Accounts Reports for one quarter with the KAI project office. The response so far has been not only extremely discouraging, but detrimental to evaluation of the program. So far, Program Accounts Reports have been received from 11 of the PCC's. (One other PCC submitted only Part One of the report.) Of the 11 reports received, ten are usable, one appearing to have obviously invalid entries on cost allocations. Although it is not yet confirmed, it is suspected that others of the completed reports also contain inaccurate and invalid data. Two of the completed forms were accompanied by caveats from the center directors revealing that some of the recorded items are not grounded in fact or in any known cost accounting theory.

It is quite obvious that PCC cost descriptions and even the most elementary forms of cost analysis are dependent upon the availability of the data contained in the Program Accounts Reports. Therefore, it is necessary that PCC's be required to submit Program

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[1] See Form F-1 in Appendix F.

Accounts Reports and perhaps be provided technical assistance to improve the timeliness and accuracy of reporting.

TENTATIVE FINDINGS AND CONCLUSIONS

Distribution of Center Costs

As discussed in the immediately preceding section, detailed analysis of the completed Program Accounts Reports is neither warranted nor possible both because of the suspected inaccuracies of the reports and because of the small number received. Therefore, the limited examination below of the data from the ten completed forms should be viewed as illustrative and should not be considered representative of the entire PCC program and perhaps not representative of an entire year's operation for the PCC's reporting.

The percentage distributions of center expenditures by program service component for the ten PCC's reporting are arrayed in Table 43. Perhaps the most striking aspect of the cost allocations shown in this table is the diversity in emphasis on the various program services by the ten PCC's. For example, the proportion of program resources devoted to services for children under three years varies from less than five percent in one center to about 38 percent in another. Six of the ten centers devote a smaller proportion of their total resources to services for children under three years than to services for parents and other family members.

As is to be expected, the centers in Table 43 with the highest proportionate travel costs are located in rural areas where the clientele population is more dispersed than in urban areas. Community development expenditures as a proportion of total expenditures are generally higher in the urban than in the rural centers.

An examination of the proportionate amount of expenditures devoted to administrative and supportive services reveals relatively high overhead costs in all but two of the ten centers, with one overhead rate exceeding 66 percent of total costs. With overhead

TABLE 43

Percentage Distribution of Expenditures, Ten PCC's
(For one quarter of 1969)

	Center									
Program Component	A (Urban)	B (Rural)	C (Urban)	D (Rural)	E (Urban)	F (Urban)	G (Urban)	H (Rural)	I (Rural)	J (Urban)
Program Services to Children Under 3	29.4	11.3	38.0	30.7	14.6	20.1	4.4	42.0	36.0	11.8
Program Services	16.0	6.3	37.7	18.4	8.1	10.8	3.8	35.0	29.1	7.8
Health Services	6.8	3.9	--	12.3	4.0	8.1	.6	3.1	2.9	3.1
Nutrition & Food	6.6	1.1	.3	--	2.5	1.2	--	3.9	4.0	.9
Program Services to Parents	12.4	30.0	20.9	20.6	49.2	23.4	10.4	12.3	11.8	13.6
Program Services	5.6	5.6	18.3	14.7	36.5	12.3	8.8	7.6	6.2	8.6
Health Services	1.5	13.8	2.3	5.9	5.3	7.1	.2	1.9	.5	4.0
Nutrition & Food	1.8	2.3	.1	--	1.1	1.0	.1	.8	1.4	.7
Classes & Instruction	2.1	6.1	.2	--	3.7	1.8	--	1.1	3.1	--
Meetings	1.5	2.2	--	--	2.6	1.2	1.3	.9	.6	.3
Program Services to Other Family Members	6.8	5.9	4.5	2.6	12.6	18.5	6.7	2.9	31.4	19.0
Program Services	1.6	1.9	4.5	--	6.5	9.2	6.1	1.7	24.7	12.8
Health Services	2.2	2.9	--	2.6	3.1	6.7	.2	.6	3.0	5.4
Nutrition & Food	2.3	.9	--	--	.5	1.3	.4	.1	3.7	.8
Classes & Instruction	.7	.2	--	--	2.5	1.3	--	.5	--	--
Community Development	13.2	1.7	--	--	3.3	9.8	3.0	3.5	.7	3.4
Administrative & Supportive Services	31.8	37.5	28.1	21.2	7.7	26.2	66.3	29.3	9.7	44.2
Travel & Transportation	6.4	13.6	8.5	24.9	12.6	2.0	9.2	10.0	10.4	8.0
Visiting Families	1.3	2.5	8.5	4.7	7.0	--	6.7	4.8	2.4	3.8
Transporting Families	4.1	5.9	--	15.0	2.0	1.8	1.6	2.2	1.4	3.0
Other Staff Travel	1.0	5.2	--	5.2	3.6	.2	.9	3.0	6.6	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

expenses varying from this high level to less than ten percent of total costs, an investigation to determine the causes of these variations appears warranted.

Estimates of National Program Costs

On an annual basis, more than $6 million in federal funds has been devoted to the PCC program. (This figure applies to the initial 12-month period when all 34 centers were operational for the full period.) Each center was granted $175,000 in federal funds for its first year of operation. In addition to this $6 million, there was approximately $400,000 to $500,000 of federal funds allocated to program administration, monitoring, and technical assistance by OEO-Washington. (Prior to receiving its funding, each center was provided a planning grant; approximately $350,000 of federal funds was expended for this purpose.) Total program costs on an annualized basis for the first full year were more than $7 million including nonfederal contributions equal to about 20 percent of the federal grants for the centers.

Based on an annual program cost of $7 million, PCC costs average about $200,000 per center annually. The average annual total cost per family served is approximately $3,840,[1] and the average annual total cost per child under three years is about $2,710.

Variations Among Centers in Cost Per Family and Per Child

By administrative edict, each PCC was funded at approximately the same level and was expected to serve 100 children under three years of age and their families. Since PCC families have an average of 1.42 children under three years, the average number of families served by a PCC would have been about 70. As noted in a previous chapter of this report, the number of families served annually actually averages 53.5 per PCC. There is a wide dispersion around this mean. This is not unexpected since centers were urged to tailor their programs and services to local needs and conditions. As other discussions in this report portray clearly, the centers do offer a wide variety of services and emphasize a variety of approaches to meeting the needs of their clientele.

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[1] This is a rough estimate based on 1,818 families enrolled in the PCC at the end of calendar year 1969.

Since all centers operate on similar total budgets and the numbers of children and families served vary, total costs per child and per family served likewise vary. Differences in costs among centers per child or per family theoretically can arise from several sources. First, the centers may have different goals;[1] that is, a center may choose to emphasize the intellectual development of children, training and work experience for nonprofessionals in child development, health care and education for children and parents, or any other of several types of services. Variations in costs per child or family served may be attributable to inherent differences in the costs of providing different program services. Second, even among programs with similar goals, costs per family or per child may vary because of differences in methods of attempting to achieve objectives. For example, two centers may emphasize child-care education for mothers, but one program may be more costly because it uses professional instead of nonprofessional instructors or because it features home visits as opposed to being centrally based. Third, among centers offering similar program services, costs may be affected by the characteristics of the clientele served (for example, the developmental level of the children) or by the dispersion of client families. Finally, among centers offering similar program services, costs may vary because of differences in management and in resulting program efficiency.

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[1] In this context, reference is to what may be called "proximate" or "intermediate" goals which are sought to be attained so that further, "ultimate" goals may eventually be attained. The ultimate goal of all centers is assumed to be as stated on the first page of this report: "to help families to function independently and effectively and for their children to develop to their full potential."

The first two factors (differences in program services and methods) are hypothesized to account largely for variations in costs per child or per family. Thus, it is difficult to compare per child or per family costs among PCC's because the outputs and services are varied. For example, the annual cost per family served ranges from about $1,400 at one center to more than $10,000 at others. The PCC's with the extreme costs per family served are vastly different. The low-cost PCC is on an Indian reservation and the program emphasizes center-based group play and day-care activities for children under three years. Two of the high-cost PCC's are in large urban areas and concentrate principally on training of mothers and home visits.

CONCLUSIONS

Cost-outcome analysis of the PCC program is impossible at this time because of the lack of either cost or outcome data. A system and procedure for analyzing costs and outcomes have been developed, but testing and implementation cannot yet be performed.

If the costs and outcomes of the PCC program are to be evaluated fully, it is necessary to have appropriate data for a cost-outcome analysis. Outcome measures are difficult to obtain, but part of the difficulty in the PCC program appears to be attributable to a lack of specification of intended outcomes. Measurement of outcomes, evaluation of progress toward achieving those outcomes, and cost-outcome analysis depend on the formulation of specific program goals and subgoals for program components.

The approximate level of costs currently incurred annually per child or per family served by the PCC is known ($2,710 per child and $3,840 per family). The figures provide only a very rough estimate, however, of program costs that might be incurred in the future. Apart from the fact that program costs may be inflated because of the experimental nature of the PCC, program cost levels will be determined by the focus of program services in any extension of the PCC. Costs appear to vary widely among the existing types of program services offered, and if only a few of the wide variety of services were selected for a continuing program, program costs per child or per family per year might be altered drastically. When adequate cost data are available from the PCC's, insight will be gained into the component costs of the various types of programs, and knowledge will be gained of the determinants of total costs.

RECOMMENDATIONS

To facilitate cost-outcome analysis that will contribute greatly to continuing overall evaluation of the PCC, the following recommendations are made.

1. The cost-reporting system designed for this project, particularly with regard to the "PCC Director's Quarterly Program Accounts Report," should be implemented fully and reporting requirements enforced.
2. The PCC program and its individual programs should establish specific goals and subgoals that are quantifiable as a first step in specifying program outcome measures that are needed and in providing a basis for measuring program progress toward goals.
3. The national PCC program should provide the necessary technical assistance to aid individual centers in formulation of goals, specification of intended outcomes, and collection and reporting of cost data.

It should be recognized that program cost data are useful for management purposes other than cost-outcome analysis. As demonstrated above in the discussion of the distribution of center costs by the various components, it is possible to perform useful cost analysis based on the data collected in the Quarterly Program Accounts Report. Therefore, it is recommended that PCC national program officials utilize the cost data as they become available for cost control and monitoring purposes to help insure that unduly inefficient operations are improved and that technical assistance needs are identified clearly.

CHAPTER XIII

MAJOR DETERMINANTS OF PARENT-CHILD CENTER PROGRAMS AND INTERVENTION STRATEGIES

The kinds of services delivered by any particular Parent-Child Center seemed most influenced by three variables that often were confounded: the educational training of the director, the location of the center, and the types of families recruited for service.

THE EDUCATIONAL TRAINING OF THE DIRECTOR

The professional training and experience of the director appear to be a major correlate of the type of program developed. To be sure, some Parent-Child Centers developed a proposal focused on social services and then sought a social worker to head the program, and others submitted proposals focused on education of children, and hence sought teachers to head the program, but the directors were nonetheless very influential in employing the other staff, training them, and developing specific job descriptions and programs. Since they generally were employed prior to the development of the Policy Advisory Committee and developed the PAC, the director was usually a key person in setting PCC policy.

The relationship between the educational background of the directors and various program variables has been discussed throughout the report, and is only partially recapitulated here. The most striking comparison is between the focus of programs headed by social workers and the focus of those headed by educators, as shown in Table 44.

Those programs that were headed by educators were far more likely to develop a Policy Advisory Committee that was parent directed, were more likely to employ parents, to focus the program on the children, to provide either day care or extensive center-based play group experiences for the children, and to focus on the education and training of the parents. These are the things educators know how to do.

TABLE 44

Comparison of Programs Directed by Educators and Social Workers

Program Attributes	Profession of Director	
	Educator	Social Worker
Program policy determined by:	Parents	Staff
Parents employed by PCC	Yes	6 of 7 do not
Primary service to parents	Education, job training	Casework therapy, social services
Focus of program	Children	Parents
Provide day care	Yes	No
Provide meals for children	Most do	5 of 7 do not

Those programs that were directed by social workers were far more apt to develop a Policy Advisory Committee directed by the staff, not to employ parents as staff (only one social worker-director did), and to provide a program focused on providing casework, therapy, and social services for the parents. No program directed by a social worker provided day care to allow mothers to work, or provided parents with job training for employment. Nearly all provided less than four hours a week contact with the target child, and only two provided one or more meals a day for the children in attendance. While three of the centers directed by social workers provided excellent medical services to the families enrolled, the other four tended to ignore the physical health needs of the families and concentrate on the mental health. All but one PCC headed by a social worker provided extensive treatment services for the adults enrolled.

While the educational training of the director seems very much related to the program components included in a center, these cannot always be separated from the location of the center, since all but one of the centers directed by social workers were in urban areas.

THE LOCATION OF THE PARENT-CHILD CENTER

Whether a Parent-Child Center is located in a rural or an urban area accounts for many differences in the availability of resources to the PCC, the auspices through which the PCC is funded, the length of time needed to initiate services to children and families, the characteristics of the staff, the number and characteristics of the families enrolled, the needs of the families, and the type of services implemented. The location of the PCC further influenced the frame of reference within which our field staff observed the PCC.

Those Parent-Child Centers located in rural areas have fewer support services available, and fewer resources to coordinate. In part, this made the implementation of services easier and rural PCC's were twice as likely as urban ones to implement services within the first seven months after funding. Rural centers were most apt to be funded through an agency developed to administer the PCC program rather than through an established agency such as a university, social service agency, public school system, or a multipurpose agency such as an NSP.

It was easier to find space in rural areas, and code restrictions were either not as stringent or not as stringently enforced, with the result that the rural centers established a total of 32 sites, or an average of almost three per center. More than half of these sites, 17, were in residences, seven in abandoned schools and five in church facilities. Space was more apt to be donated in rural areas than in urban ones, thus freeing money for staff and services. Multiple sites served to reduce travel time for both staff and families.

The staff in rural areas, like the families served, is most apt to be Mexican-American, other Caucasian, or American Indian. The Black staff is employed in urban areas where the Black families are enrolled. Most rural PCC's are staffed in such a way that almost all of the contacts between staff and family are made by nonprofessionals. Five of the PCC's are staffed so that professionals supervise the nonprofessional staff and only the nonprofessional staff has contact with parents and children. Four others have all nonprofessional staff. In both these cases, the contacts between staff and families are made by the nonprofessionals who are either parents or other target-area residents, and with whom the parents communicate easily.

Most families enrolled in rural areas are either Mexican-American, other Caucasian, or Indian or Eskimo people. Only five percent of all Black families enrolled in PCC's live in rural areas. The rural parents--particularly the Mexican-American and the other Caucasians--report far fewer years of education than do the urban parents, and particularly the Black parents. In one rural PCC where almost all the families are Caucasian, 86 percent of the fathers and 79 percent of the mothers have less than eight years of education.

Most rural families are headed by a man, but up to 59 percent of these fathers were unemployed at the time of intake to the PCC. While ten of the 16 fathers employed by the PCC's were employed in rural centers, the PCC itself certainly could not be considered as an important source of employment for the men in these rural families. With three exceptions, there is little employment available in the communities. The exceptions are the sites in Alaska, the center in a migrant farm labor camp, and one PCC in a rural area that happens to have an industry in the town. The lack of employment opportunity for men in these rural areas is a far more crucial determinant of poverty than it is for many urban families.

The living conditions and the poverty of many of these rural families are profound, and cannot be compared to conditions in most of the big cities. Not only do these families report a per capita income far less than their urban counterparts, but many live in dilapidated shacks which they own, but cannot afford to repair. In three rural areas, all in very cold climates, more than 69 percent of the families do not even have running water. Much of the year it is too cold for the children to play either outside or in, and the floors of the shacks are in such poor condition that the children cannot even be allowed to crawl.

In part because the rural programs have been in service longer, but not entirely so, these PCC's deliver more hours of service to more families and children than do the urban programs. The rural centers are currently serving an average of 61.8 families, while the urban ones have an average enrollment of 49.5. The rural PCC's are serving an average of 89.2 focal children and the urban centers an average of 57.2. Part of this difference is due to the fact that the rural families are larger than the urban families. While one rural center does not provide any home visiting at all, another provides over 500 hours per month, with an overall average of 179 hours of home visiting. The urban centers average 151 hours of home visiting, in spite of the fact that they spend less time in travel to get to their families. While eight of the 11 rural centers provide a center-based program for the children for more than five hours per week, only 12 of the 23 urban programs do. Seven of the 11 rural centers provide one or more meals per day for the children attending the center as compared with nine of the urban centers. Because there was a lack of public sources for medical services in rural areas, these PCC's made their arrangements with private sources. In spite of the shortage of available medical resources, the families in rural areas received more medical services than did those in urban areas.

While only one rural program provided any kind of a structured or formal plan for intervening in the cognitive and developmental progress of the focal children, they provided a large number of center-based play groups as well as day care, both at the center and in day-care homes. Of the 316 children in day care, 223 are in rural areas and only 93 are in urban areas.

While there are real differences in the quantity of service being provided in rural areas, we also discovered a kind of bias among our field staff. The abysmal poverty of many of the families in rural areas led one of our field staff to write, "In thirty years of doing social work, I have never seen such poverty." Since the rural centers were particularly strong in the social service component designed to meet the material needs of the families, it is not surprising that our field staff viewed their accomplishments positively. When one of our observers saw a cold baby wrapped in a blanket by a PCC aide, food provided for the family, a sick mother taken to the hospital, and a leaking roof repaired, it was inevitable that the observer should report positively on these vital services. On the other hand, these material needs were usually met in most urban areas by welfare departments or other agencies to which the urban PCC's could refer the families. Because these basic material needs are either already met, or can be met by referral to another agency, the urban PCC's are in a position to provide more sophisticated interventions. The expectations of our field staff who visited the urban PCC's were on a different level. They expected the staff of the PCC's to have a plan, not just to relieve the physical conditions of poverty, but one that would get at the roots of the psychological and cognitive sources of poverty. On these urban centers our field staff made comments such as, "This center appears to have no comprehensive strategy for intervention," or "This staff is operating intuitively. There seems to be no understanding of the progressive cognitive development of children," or, "The weakest part of this program is the children's component. The staff does not seem to have an understanding that cognitive development is sequential, or that it is an inseparable part of the entire developmental process."

That observers as experienced and well trained as ours should apply different standards to rural PCC's than to urban ones suggests that the needs of the two groups of families are so different that it would be inappropriate either to provide the same kinds of services or to apply the same standards in evaluating these services. There is an old saying which goes, "First eat, then think." Abraham Maslow in a more scientific way has pointed out that lower level needs must be met before energy can be released to pursue higher order goals. Our field observers have reported on the achievements of the rural centers even when they operated under the most severe handicaps of limited resources, untrained staff, and poor program planning; as one stated:

> This staff has, without a doubt, produced some very worthy results and done so under the most trying handicaps. In part this reflects the dire needs of the rural poor; any attention and assistance would be at least of temporary benefit to them. In all likelihood this program has also demonstrated that untrained workers, even without adequate consultation and supervision and only vaguely aware of the theoretical foundations of the PCC, can and do provide a climate for acculturation.

On the other hand, when our field observers viewed a very similar program in an urban setting, they tended to be more critical if the toys were not appropriate to the age of the children, if the activities were not tailored to the developmental stage of the participating children, or if the curriculum did not allow for a progression of skills and experiences as the children developed. In short, our field staff tended to settle for less in the rural areas, and to feel that any intervention that relieved the sheer physical misery of the lives of the PCC families was an achievement.

Aside from the PCC program, many rural areas offer no other source of help for these poorly educated families with unemployed heads of households. In contrast, the young, Black mother with many more years of education who lives in an urban area where employment is available at least to the skilled has vastly different needs. In many urban areas, the sophisticated poor can shop to find a program that best meets their needs. Some few urban poor are sophisticated enough to be appointed or elected to boards of poverty agencies so that they can help tailor the program to meet their needs. Our field staff felt that the urban families needed a different type of intervention to meet the needs of these better educated, more employable parents.

STRATEGIES FOR INTERVENTION WITH DIFFERENT PCC GROUPS

It is always necessary to define the target population clearly when developing an intervention strategy, and to tailor the strategy to the needs of the particular group served. From the reports of our field staff, as well as the demographic data from the centers, the PCC families might be categorized in a four-cell classification as described by S. M. Miller[1] and illustrated in Figure 4.

> The Stable Poor
>
> Cell I is characterized by stability, economically and familially. This cell points to regularly employed, low-skill, stable poor families....The rural population, both farm and nonfarm, undoubtedly make up the bulk of the stable poor....
>
> The children of Cell I families are of all the children of the poor those most likely to be educationally and occupationally mobile.
>
> The Strained Poor
>
> Cell II...portrays a secure economic pattern, but an unstable family pattern....This might involve a life-cycle problem, i.e., at certain points the families of low-wage, unskilled workers are likely to exhibit unstable patterns. Examples might be "wild" younger workers or alcoholic older workers who disturb family functioning....Many of the offspring of strained families may fail to match the economic security of their parents.

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[1] S. M. Miller, "The American Lower Classes: A Typological Approach," Journal of Social Research, vol. 31, no. 1 (Spring 1964).

The Copers

The copers of Cell III manifest economic insecurity and familial stability--families and individuals having a rough time economically but managing to keep themselves relatively intact....Probably a number of Negroes are in this group and their children are more likely to be mobile than those living in Cell II-type situations.

The Unstable Poor

In Cell IV, the unstable have neither economic nor personal stability. Within the unstable group there are degrees of stability and strain--not every family is a "hard-core case" or has a "multi-agency problem."...While some frequent concomitants of low income life such as matrifocality do not inevitably produce grave difficulties in family life, they frequently do. Alcoholism, an inability to handle aggression, hostility or dependence--one's own or others' toward one--can deeply disturb family functioning. A variety of direct personal aid may be necessary.

FIGURE 4

Miller's Cross-Classification of Poor Families

		FAMILIAL	
		Stability	Instability
ECONOMIC	Security	I The Stable Poor	II The Strained Poor
	Insecurity	III The Copers	IV The Unstable Poor

It should be pointed out that not all two-parent families can be considered "stable" nor all single-parent families "unstable." Some two-parent families are highly unstable, and solo parents can provide a high degree of family stability to their children. Further, not all economically insecure families are unemployed; some are employed intermittently at such low-skilled, low-paying jobs that the family never gets any sense of security. On the other hand, in some states at least, welfare benefits can provide a solid base of support, and even if the economic level is very low, it is at least secure.

It is clear that no shotgun approach to the needs of these very different kinds of families is appropriate, and not only must different services be developed depending upon the preponderance of the type of families enrolled, but there must be different interventions possible within any one center. The families in Cells I and III, which show family stability but are either economically secure or insecure, are most apt to be enrolled in rural Parent-Child Centers, but some are enrolled in urban centers. While some families that show familial instability are enrolled in rural centers, most are enrolled in the urban centers. For the most part, each of the Parent-Child Centers has developed an intervention strategy, trained the staff according to this strategy, and then provided the service for all families enrolled, regardless of the appropriateness to the individual family.

The PCC's have based their programs on one or more of the existing strategies for change:

1. A program designed to change the parents by providing medical services, counseling, treatment, and casework, so that the parents will in turn be able to nurture their children.

2. A program designed to increase the economic position of the families by providing day care in order to free mothers for work, or by providing adult education or job training and placement.

3. A long-range, child-focused strategy to provide early education for the infants and toddlers, and to teach their mothers how to continue these educational interventions.

A fourth strategy exists but is not a major intervention strategy of the Parent-Child Centers. This fourth strategy is the indirect one, based on the attempt to change the environmental conditions and the institutions which affect the poor, including community action for the change of these institutions and economic development of the area.

Each of these strategies has sufficient merit to warrant careful data gathering and research on its effectiveness as an intervention technique. It is, however, necessary to recruit families appropriate to the strategy selected by the particular center, rather than to try to fit the needs of the family to the strategy developed by the center. If the needs of the four groups of low-income families are examined, it appears that certain strategies are more appropriate to one group than to another.

The Stable Poor (Cell I)

What these families need most is money or the chance to earn money. In urban areas the PCC might provide these families with referrals to jobs, or job training. Day care for the children might release some of the mothers to find employment. These families can also benefit from medical services. In rural areas where the bulk of the stable poor live, employment opportunities are often too scarce to make educational or job training programs worth the costs. Though the majority of day-care slots within the PCC are provided in rural centers by the choice of the parents, most do not result in the mothers finding employment, for virtually no jobs exist in the community. In these rural areas, the parents are often so poorly educated that employment at any but the lowest level of skill is unlikely. These families usually do not require much in the way of social services other than those to meet their material needs. The PCC is probably not an efficient way to distribute income. These parents might best be served by a program of income maintenance not tied to job training but perhaps to basic education.

The children of the stable poor in both rural and urban areas are apt to benefit more than other groups of poor children from play groups, infant education, or other child-focused programs. The stability of these families is such that the parents are usually able to implement the educational and enrichment activities demonstrated by the staff of the PCC's.

The Strained Poor (Cell II)

These families are somewhat secure economically but have unstable family lives. Some of the families in the PCC's have achieved this low level of economic security through employment and some through welfare benefits. Families such as these, of all ethnic groups, are found in both rural and urban PCC's, but most are in the urban Parent-Child Centers. For these families, there is a great need for social service supports of all kinds. Programs to provide for their material needs, also casework, counseling, treatment, and medical services, as well as educational programs and job training, can all be utilized by these parents. Those rural families that have unstable family situations can probably also benefit more from a program of income maintenance than one of job training.

The children of the strained poor can benefit from a play group situation or a program which removes them for a part of the day from the tensions of the family situation. The mothers can probably also benefit from a few hours relief from the care of small children. The parents of these children, like those of the unstable poor, often do not have the emotional energy to meet the needs of their children, and the PCC staff can fill this gap in the lives of the infants and children.

The Copers (Cell III)

These families are economically insecure though they have a high degree of family stability and make up the bulk of the families of the PCC's in rural areas. These are the two-parent families with unemployed fathers. Included among these PCC families are Mexican-Americans, other Caucasians, and some of the American Indian families. The parents in these families are also very poorly educated and have little access to employment. Like the stable poor of Cell I, job training in rural areas is of little help since there are no jobs. These families need income more than they need social services, though they can almost always benefit from medical services.

The children in these families usually participate in and benefit from the infant development programs provided by the PCC's, and the parents participate in the recreational and social activities of the center. However, their basic need for jobs and money is not usually met through the PCC.

The Unstable Poor (Cell IV)

Lacking both family stability and economic security, these are the hard-core poor families that many of the Parent-Child Centers, both rural and urban, have elected to serve. A survey by Bradley Buell of 108 private and public agencies in St. Paul, Minnesota showed that 46 percent of the health services and 55 percent of the adjustment services, including both psychiatric and casework services, were consumed by six percent of the families served by these agencies. Where such families account for 80 or 90 percent of the caseload, as they do in some Parent-Child Centers, the task is monumental.

Few Parent-Child Centers have sufficient resources or are staffed in such a way that very many of these unstable families can be given the constant support they need within the budget allocations of the program. These families can absorb most of the staff time of a PCC and still live their lives in an almost perpetual state of crisis. Inexperienced staffs quickly become demoralized as they constantly strive to bring some stability into the crisis-laden atmosphere of these families. In the long run, it is more humanitarian to recruit these hard-core families selectively, and to assign only one or two to each social service aide.

Most of the parents, particularly the mothers, in these families need prolonged service and support before they can reasonably be expected to seek or hold employment. However, day-care services as well as center-based play groups do provide an opportunity for the children to develop in an environment free from crises for at least part of their lives. Group care of these children also provides an opportunity for these "depleted mothers" to recoup some of their physical and psychic energy. These families can and have been worked with successfully, but require a massive commitment of staff time and agency resources. Those Parent-Child Centers that have elected to serve only these very unstable families have not been able to serve more than 30 families in the intense way necessary.

CONCLUSIONS AND RECOMMENDATIONS

If we plot these recommendations on a chart, it is clear that no one "model" is appropriate for all Parent-Child Centers. Table 45 is neither a total catalog of PCC services, nor the only possible, classification of the enormously heterogeneous collection of people who have low incomes. Rather it is an illustration of one possible, rational approach to program design that takes into consideration the conditions of the area in which the PCC is located, the needs of the families, and the intent of the program.

As the table indicates, job training is not appropriate in rural areas where employment opportunities are scarce, nor is it appropriate for very unstable families until they have received other program supports. Day care in rural areas will not generally result in employment for mothers--as the jobs do not exist--and therefore may be an unnecessarily expensive method of providing the children with stimulating experiences. Stable families do not need and sometimes resent the attempts of social service workers to "meddle" in their lives. They

TABLE 45

Proposed PCC Program Strategies by Family "Type"

Predominant PCC Location	Stable Poor		Strained Poor		Copers		Unstable Poor	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Economic Services								
Job Training and Referral		X		X		X		
Income Maintenance	X		X		X			X
Material Supports	X			X		X		
Family Services								
Casework			X	X				X
Basic Education	X	X		X	X	X		X
Medical and Dental	X	X		X	X	X		X
Children's Services								
Day Care		X				X		X
Stimulation	X	X		X	X			X
Play Groups	X	X	X	X				X

can, however, benefit greatly from basic education programs, and from job training where employment possibilities are available.

What we are here suggesting is that the Parent-Child Centers examine the existing strategies for intervention, diagnose the potential of the community and the needs of the family, and employ an appropriate strategy for the particular family. Recruitment of families might then be made on some rational basis, so that when there is an opening in a job training program, a family that could benefit from job training would be accepted, rather than one that needs extensive casework.

Further, if centers were to define the predominant type of family to be recruited, they could also have a rational basis on which to set educational specifications for the director and to define the major program components. Those programs electing to serve the strained and unstable poor might well specify a social worker for the director. However, those programs in urban areas that enroll young, employable mothers might well be directed by educators who are more likely to provide day-care services and to employ parents or train them for jobs. As it is now, most of the day-care slots have been developed in the rural areas where there is limited employment available and most of the casework is being provided to fairly well-educated young urban mothers, who might find a job better therapy than counseling. Previous studies have shown that middle-income Black women have far fewer children than low-income Black women or middle-income White women. For many of these young Black women in urban areas who are already being counseled through their second pregnancies in the PCC's, job training and referral might be more appropriate interventions. To repeat, the need is for PCC's to examine available intervention strategies, analyze the potential of the community and the needs of the families, and then employ an appropriate strategy.

CHAPTER XIV

GENERAL CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

Previous chapters of this report have dealt in some detail with almost every aspect of Parent-Child Centers. Specific conclusions and recommendations have been provided in various chapters which are not repeated here. This chapter focuses on the PCC program as a whole; first, as a demonstration and, second, as an operating activity. The chapter contains questions and suggestions we think specifically relevant to the design of programs for infants and young children as well as others generally relevant to other demonstration programs.

Criticisms of the program as a demonstration are offered in the following section of this chapter. It is recognized that a great amount of useful data have been obtained and that many useful insights and analyses have already been developed from the program. The criticism focuses less on what has been done than on what might also have been done and can yet be done to make the program an even more useful demonstration.

Criticisms of the program as an operating activity are also offered as are suggestions for its improvement. Again, these criticisms and suggestions are offered not because the program is considered bad or ineffective but because there are opportunities to improve it, building on the present base.

The final chapter of this report, prepared by Dr. Lois B. Murphy independently, also provides conclusions and recommendations. It does so within a broad perspective of the desperate needs of poor families and their children and also the evolutionary development of any important endeavor. Reading both these chapters provides somewhat different but complementary perspectives, conclusions, and recommendations.

THE PARENT-CHILD CENTERS PROGRAM AS A DEMONSTRATION PROGRAM

Demonstration programs ordinarily serve to illustrate or try a new technique or procedure for accomplishing specific goals or delivering specific services. The major variables or conditions relevant to a program's hypotheses are identified and are related to its choice of site, administrative and technical staffing patterns, its choice of clients, and, very concretely, the activities or program to be carried out. Frequently, specific outcome criteria are specified in advance, and provisions for measurement of outcomes are built into the program's internal operations. Because a demonstration program can affect many future programs, its experimental features are guarded, and the prespecified program is closely adhered to until sufficient data have accumulated to support specific changes or to meet the data requirements of the investigative design.

Such safeguards of sampling and design are imposed in demonstration programs to help obtain usable and replicable findings that can serve as guides to future program decisions.

None of these normal scientific preparations appear to have attended the launching of this program.

> --We have been unable to discover any rational basis for the selection of the communities involved. They are not a stratified sample of any kind. They are not geographically, demographically, or ethnically representative of the country as a whole or of the distribution of poverty. Indeed, several of the communities have had difficulty locating a sufficient number of families to meet the original criteria for eligibility. The critical issue of sampling--so vital to the design of an assessment of a differential delivery system--was apparently left to chance.

--The goals defined for the program and the program criteria were so sweeping, so broad, and so ambiguous as to defy behavioral definition or specification of outcome measures.

--Program definitions were vague and unstructured--in the name of freedom of local choice and a stated desire to generate program variability. Yet constraints were imposed on the program that automatically limited choices, but in ways that were unpredictable. For example, all programs were granted to or through Community Action Agencies. There is insufficient knowledge about that still novel theory of community organization to predict what kinds of program constrictions would be thereby imposed. The same is true for such other requirements as 50 percent membership by parents on the Policy Advisory Committee, with no firm definition of its role.

--No basic theoretical issues were posed--or tested--and the range of approaches tried was thus nonsystematically produced. Our classifications of programs in this report are post hoc deductions--not statements of intent by the program's managers or directors.

--No outcomes or hypotheses were posed--and whatever measurement occurred was imposed from without.

--While the PCC's have delivered a great deal of service to the families enrolled, for the most part they did not provide this service in any systematic way, and are not prepared to describe what they have demonstrated.

This lack of clarity and definition in turn affected the operation of the centers themselves. One of our associates assessed the situation in a rural center:

> In a setting such as the one in which this PCC is working, where the problems are so numerous, complex, and inter-related, it is difficult to know where to begin--should it be with the child's motor development which is often retarded because of home conditions--should it be with language and the inability to handle other abstract symbols, which often create a problem for these people when they try to move out into the broader society--should it be with the attitudes of apathy and defeatism that stand in the way of using opportunities which might exist--should it be with the school system which is antiquated and ill-equipped for the responsibility it is charged with--should it be with the lack of training facilities available, or the job opportunities that don't exist, etc.--and how should it be done in two locations on a budget grossly inadequate for one--and with a staff that is well-intentioned but lacks the knowledge and skills needed to know where and how to begin. These are some of the decisions that faced the PCC and which went unresolved throughout the funding period. Instead of developing a master plan, focusing on a manageable segment of that plan, and providing sufficient training and supervision to enable the staff to function with a sense of mission and authority, the center staff spent a great deal of their time, energy, and as a result, their funds, in a scattered approach to doing what they could see needed doing at the moment. Much of their program, then, became a random pursuit of minutiae.

Why did this departure from the original "research" intent occur? First, the program was directed, at both the national and local levels, by humanitarian, service-oriented people who were primarily interested in delivering services. There are only two PCC's which have employed any staff with research skills, and in one of these, the researcher is restricted to the role of "observer." The conditions for a demonstration related to an effective research and evaluation effort were not enforced at any level of program administration. Fundamentally, the program was not designed or conducted as a demonstration but as an operational service activity.

Second, it is exceedingly difficult to run operational programs along the same lines as laboratory experiments with controlled conditions. All sorts of complex pressures exist and compete when programs actually operate. They deal with real people and all their vagaries and hosts of important institutional and other environmental factors that often can not even be identified at the outset, much less controlled.

Third, certain organizational factors were required that worked against a research orientation for the program. The centers, small as they are, were generally embedded in a CAA structure with a multitude of complicated levels, relationships, and requirements. Additionally, because of the broad nature of the PCC goals, a host of other relationships seemed inevitable. Centers struggled to cope with these organizational and administrative problems as well as to provide services. In this environment, research did not even enter the competition for attention.

Fourth, a broader, more open research strategy was favored on the assumption that it was premature to establish the "scientific" preparations referred to earlier. Knowing so little about how to work with these types of families, the thought was to move ahead with an open and free design and perhaps later attempt to develop a more experimental approach when we have a better idea of the hypotheses to test, the alternatives to consider, and the controls that might be relevant and realistic.

A further factor that inhibited the conduct of a research-oriented demonstration was involving parents in policy-making positions at centers.

The conflict between the Policy Advisory Committee and the CAA or delegate agency due to the lack of clarity of the guidelines has already been discussed. Other problems in setting policy developed at some centers because of the requirement that parents comprise 50 percent of the Policy Advisory Committee. While there are many benefits to participating parents and to the program in having parents take a major responsibility for decision-making, there are also drawbacks. In a number of centers the parents decided that they should exclude from participation in the PCC any children whose mothers did not attend and assist with the work of the center. In some cases, this meant that children most in need of the PCC services and activities were terminated by demand of the parents on the Policy Advisory Committee. At other centers, the parents decided that only the children of nonworking mothers could attend. At still other centers, the parents had so many unmet needs of their own that they could not really even begin to focus on the needs of the children, and to expect other kinds of decision making of these parents is to place too great a burden on deprived people. Further, it must be expected, that where parents are actually allowed a major decision-making role, they will overwhelmingly choose day-care programs for their children rather than the part-time, play group experience envisioned by many PCC planners. The right of all Americans to make decisions which affect their lives is not being questioned here. What is being stated is that when low-income parents are given half of the positions on the Policy Advisory Committee, they will make some important decisions which the professional staff and the national planners did not expect and might find hard to accept.

Among these difficult to accept decisions will be the refusal to allow research to be done in the PCC's. Low-income parents who have decision-making power over the allocation of funds will not vote those funds to conduct research programs. As one mother stated poignantly, "I know all I cares to know about being poor. I is not going to vote five cents to learn more about poverty." It would appear to be unreasonable to expect poor parents to divert funds away from direct services to pay for research consultants, data collection or processing, testing, measurement or evaluation. The great fear of research or any data gathering in poor communities must be accepted not only as a restriction on research, but as a measure of the suspicion many poor people of all ethnic groups have of government programs. Fron one end of the country to another, the rumor is passed through Black ghettos, "They are gathering information about us to carry out a plan of mass genocide." On the Indian reservation, the rumor was, "There are not enough White babies being born, so they are opening a center to steal our Indian babies for adoption." Because of these acute fears, real though unfounded, it is almost impossible to do research or gather data except through a service organization that is well rooted in the community. When the decision to do the research and to allocate the funds to carry it out are the responsibility of the parents, it is unlikely that they will opt for research. It may well be that the need for information in a research and demonstration program is not compatible with control of policy by parents.

Although much has been learned from the program, the demonstration was not designed to answer systematically a number of important questions. For instance, as previously indicated, the whole area of costs and their relationships to program elements and outcomes has been little illuminated by the demonstration. The issue of the merits of engaging parents as staff members could not be explored fully in this demonstration as it was designed. As a result of what has been done we cannot say with assurance whether employing parents as staff members is an effective strategy in terms of outcomes and costs involved.

A number of other issues seem worthy of the type of careful exploration that might have been possible in a more rigorously designed demonstration. For instance, there is doubt that the needs of the very poorest families can be met by the PCC program as presently constituted and funded. Food, shelter, clothing, hope, and income seem to be prerequisites if parents are to be able to focus energy on the affective and cognitive needs of their children. While some programs sought to serve the very neediest families and others did not, the different strategies were not designed or employed in such a manner that it is possible to determine their relative efficacy. Still another problem that might have been more effectively illuminated by a more careful design is whether or not to have a number of separate sites funded from one PCC grant. A number of programs were divided into two or more sites but necessary preparations were not made to enable a really systematic analysis of their relative success.

According to members of the Task Force which designed the PCC program originally, this was to be a program for children under three, primarily, and would provide auxiliary services for the rest of the family to the extent necessary to serve the child. J. McVicker Hunt, who chaired the White House Task Force, comments, "In dreaming up the centers for children and parents as described in A Bill of Rights For Children, the members of the White House Task Force focused on the needs of the children rather than the needs of parents....The (--) Center, however, has started with the needs of parents."

Given its present resources, it appears that a PCC cannot do both jobs well. The major policy question implied has not really been faced: Is this a program to assist in the development and education of infants and toddlers, or is it a program to lift parents out of poverty? Can one be done without the other? The relative effectiveness of these approaches can best be tested over a considerable period of time and with the proper design, record keeping and other normal concomitants of systematic longitudinal research.

In spite of the limitations of the PCC program as a demonstration, much has been learned. Some of the important conclusions follow.

CONCLUSIONS

Development and Viability of the Centers

Thirty-five of the 36 centers originally contemplated are going enterprises today. In view of the many difficulties faced by the centers this, in itself, is an important accomplishment. As previously indicated, they had a broad, complex and difficult mandate; they were enmeshed in a multilayered organizational labyrinth; they were often in communities without adequate supportive services and facilities; and they attempted to utilize slim resources to deal on a broad front with the full range of problems of the most destitute and disorganized families.

While the nature of the achievement in coping with these difficulties is not to be underestimated, there is some merit in considering whether many of these difficulties might have been avoided at the outset by more careful planning. The PCC program is not the first antipoverty effort and many of the problems encountered have been frequently noted in evaluations of other projects of a similar character. Consequently, it is probably likely that quite a number of the developmental and subsequent operating problems need not have been encountered, if the program had been more thoroughly planned. It is hoped that the findings of this project will be helpful in planning subsequent centers.

The Nature of the Programs

The tenor of the early thinking and planning from which the program eventually developed indicated that this was to be a program focusing on the infant--that was to be the unique and distinguishing aspect. This emphasis grew from a recognition that the prenatal and infancy periods were not only crucial to subsequent physical, emotional, and intellectual development but that they were largely being neglected in terms of federal programs for the poor.

Regarding all of the PCC programs in operation, one is led to the conclusion that at this point in the development of the centers, their focus tends to be far more on parents than on infants. Having a child of the appropriate age is a criterion for admission to the program but the actual programs have relatively little (in terms of what they might have) for the child. There are far more components designed for adults than for infants. More time and money are devoted to parents. The staffs are better qualified to deal with parents and, indeed, in most cases there is a general purpose social service program (a mini-CAA) with, and in some cases without, a small infant program. To categorize the PCC program, as it now exists, as a demonstration effort to overcome prenatal and infancy problems, tends to be both limiting and misleading. A fairly strong indication of this is that most experts believe that nutrition is a crucial element in the prenatal, perinatal and infancy periods. One might, therefore, expect to find that nutritional programs are central and pervasive in PCC's. Quite the opposite is the case.

Thus, while many centers do contain elements directed to infants, the program is much less concentrated in this area than might originally have been anticipated.

We have learned that it is extremely difficult to launch a baby-oriented program when the basic desperate needs of the parents are not met--especially when the parents are instrumental in setting program policies. There are some tentative indications that programs for this type of family do concern themselves with the children once certain minimal needs of the adults are satisfied. It is not yet certain, however, if this trend in some centers will persist, will be found in other centers or how the focus of center programs will eventually evolve.

Program Administration

Administrative problems were encountered at every level of the program as might be expected in a fledgling enterprise. A number of these are reviewed not to dwell on what may be perceived as inadequacies but to indicate ways to learn from what has happened so that more effective programs can be devised.

The program was seriously understaffed at the Washington level from the outset. Although not a large program by federal standards, it was new, complex and varied. Moreover, it was to serve both as a demonstration and as an active provider of services. Further, it is designed to coordinate many local organizations and services. In spite of these demands, initially three persons and later four constituted the national (Washington level) staff for the program. Complaints from centers concerning the national administration of the program were endemic. They generally focused on difficulties of obtaining firm responses to inquiries, lack of sensitivity to local problems and outlooks particularly in rural areas, and the paucity of useful federal assistance in program development, technical matters and policy selection.

A crucial element in most new programs is the provision of adequate technical assistance. PCC's were in particular need of such help because of their broad range of goals and programs and because knowledge about the most effective approaches with the infants of the poor is not commonly available.

Technical assistance was provided the centers by a Project Adviser, usually from the field of nursery education, who visited four days a month from a different city. Only one adviser was selected for each center in order to give continuity to the relationship and it was thought that the adviser's residence in a different community would remove him from local political issues and pressures. Quite naturally, the value of the adviser to a center was largely related to the characteristics of the particular individual working in this role. However, as a general rule, it was exceedingly difficult for one adviser, no matter how talented, to satisfy the very diverse needs of the centers. Further, the lack of propinquity of the advisers tended to inhibit the type of continuing, informal, problem oriented help that a more accessible professional might have been able to provide. The advisers were handicapped in their effectiveness, also, by not "knowing the ropes" in the PCC community where they assisted, particularly in terms of obtaining services from other local institutions.

At the local level, as previously indicated, these small centers were expected to carry a really enormous administrative load and to cope with an almost unbelievable variety of relationships and requirements. In most cases, contrary to plan, association with the CAA created administrative problems for centers without solving coordination problems. Further, the CAA's often compounded the problems by delegating the PCC program to a traditional social work agency, a public school system, or a special agency. No PCC was delegated to an established infant care agency although several such agencies exist in most major urban areas.

Many of the substantive problems of working with infants and their parents encountered by PCC's were probably unique. The administrative problems, however, are relatively common to these types of programs and it appears that many might have been avoided.

Program Strategies

Some attention has been devoted to a discussion of program strategies in a previous chapter. It is believed important to reiterate a number of findings and conclusions dealing with this subject.

First, the particular methods that were utilized to design and develop programs resulted in almost all of them being quite different from each other. While certain components seemed to be quite common, others were not and it would be almost impossible to construct fewer than thirty-five models to describe adequately what has occurred. The research difficulties created by this result have been discussed.

It is also interesting that the strategies employed were rarely innovative. One always hopes that the free play of many minds tackling similar problems will result in numerous insights of widespread value and new methods of particular efficacy. It appears that such developments either have not yet taken place or have not yet been identified. Indeed, some of the approaches utilized, as previously indicated, appear to be counterproductive. It does appear, therefore, that additional thought needs to be given to the methods of developing local strategies to achieve PCC's national goals.

Mobility and Turnover

Documented frequently in this report are the favorable responses of many families served by the PCC's. Indeed, it was uncommon to hear complaints. In spite of this, the data indicate that the turnover of PCC families will not be less than 25 percent per year and may well be as high as 50 percent--a figure not uncommon in ghetto area public schools. Neither monetary incentives nor the services provided have been sufficient to reduce this turnover even in the most active centers, both urban and rural. The turnover problem is exacerbated in some centers which bar further service if a mother goes to work or does not attend center functions.

This high rate of turnover poses very serious problems for the program. The interventions provided by the program that are postulated to be effective take time to be fruitful. The development of a child and families can not be rushed. It may well be that brief interventions by a center are not a good investment and a carefully designed longitudinal research effort might explore this issue. It does seem, however, that the turnover problem needs recognition and efforts to deal with if not overcome it.

Program Content

The programs for children are the weakest components of the Parent-Child Centers. In Dr. Hunt's paper, the reader may have noticed the line which read, "For the infants aged 18 months to three years, the program differed relatively little from that for children three to five." That was not an exceptional observation. In most center play groups, it was difficult to distinguish and differentiation of program for the smallest children as compared to the older.

Indeed it often appeared that the programs were simply Head Start classrooms--with activities and equipment designed for four- and five-year-olds--into which two- and three-year-olds had been introduced. With few exceptions, the toys, trikes, chairs, tables, sinks, toilets, and puzzles were too big and too complicated for children under three. Often the equipment and toys were selected from Head Start lists or came straight out of the Creative Playthings preschool catalog.

These indicators of lack of knowledge about children under three were accompanied by frequently observed and reported behaviors displaying similar lack of knowledge on the part of the staff. Staff were almost uniformly kind to the infants; they clearly cared about them and wanted to do a "good" job. The problem with their care was that most had so limited a repertoire of activities to engage the infants--and a limited knowledge of the characteristics of children this young. In addition to displays of warmth and affection, we received reports of staff who misjudged children's ages by a whole year; failures to talk sufficiently to the infants "because they don't understand"; and threats of punishment for ordinary exploratory activity. In several centers we saw infants, preschoolers, and school-aged children in the same group so that the crawlers were endangered by the running and trike-riding four-year-olds. In still others, we saw babies kept in cribs all during their visit, because the staff didn't know what else to do with them. In one center, the "program" for infants consisted of paper mobiles hung over the crib--but these were oriented to be visible only to a standing adult; the baby was seeing only their edges.

Many PCC staff had had prior experience in OEO-sponsored projects, and so knew a good deal about such things as working with paraprofessionals and delivering social services. A large body of experience and a variety of alternates exist for the delivery of medical services. Building upon these, the PCC's were able to mount such program activities quite easily. Their most limited knowledge is in the area of how to work with infants and toddlers.

Further, the survival needs of many of the PCC families were so intense that many directors felt impelled to give these priority over infant education. The pressing need of the parents combined with the limited knowledge of many staff in working with infants and toddlers resulted in the frequent finding that the children's component was often the least innovative or appropriate.

Undoubtedly, the staffs of the Parent-Child Centers have learned a great deal about intervening in the lives of low-income families with children under three, and in many cases have done so effectively. Few, however, have kept the kind of records or described the process in such a way that what has been learned could be described or the demonstration replicated.

If the PCC programs are to continue to be involved with infants and toddlers, it is evident that there must be an improvement in the way knowledge, understanding, and technique concerning these young children are provided to the staff. If this is not done, the concept of intervening directly very early in the life span may not have been adequately tested by this program nor is it likely that an effective component for infants will be prevalent.

Costs

The design and administration of the demonstration, at present, completely thwarts any attempt to do useful cost analyses. Conclusions in the area of costs cannot be presented with any assurance of their reliability except for one. It is expensive to do what the centers are attempting to do in the way they are attempting to do it. The term expensive is used in comparison not with actual or potential benefits nor in comparison with other programs with similar goals but solely in comparison with a minimal income for a family. If more adequate records are not maintained on costs, activities, and outcomes as well as alternative strategies, it is possible that the fragmentary cost data now available will be used to make decisions that damage the program before it is adequately tested.

SUMMARY

It is always easy to look back at a program and to perceive all the things that should have been done or done better. It is exceedingly difficult, however, during the turmoil of program genesis and development and in the midst of competing real-life forces to exhibit calm insight and prescience. The conclusions of this report obviously have the benefit of being developed after the fact. They are meant to be useful and constructive. The same is true of the recommendations that follow. Some of these can apply to the development of new programs. Others can be applied to this program only because it has advanced to its present status.

The evolutionary nature of a program of this type is important and is emphasized in Dr. Murphy's paper which follows. Perhaps the most important conclusion concerning the PCC program is that it appears to have passed through its birth pains and is now an operational reality. The issue is no longer how to make it exist but how to make it better. Most recommendations are addressed to this latter issue.

RECOMMENDATIONS

Many specific recommendations have been presented throughout this report. A number are repeated here for emphasis and other broader ones are introduced for the first time. Recommendations are organized into two broad, overlapping categories dealing, first, with how to make the PCC program a more effective demonstration and, second, how to make it a more effective operating activity.

PCC as a Demonstration

Policy Decisions Required

Perhaps the first and most crucial need is to decide if the PCC program is really to be run principally as a demonstration, with all that implies, or principally as an operational program. Clearly these are not alternatives but a matter of relative emphasis. As indicated previously, it appears that the relative emphasis has been toward the operational aspects of the program. It is suggested that it is now appropriate in terms of the stage of development of the program and what has been learned so far to shift the emphasis more toward the demonstration aspects. The decision must be made specifically and at the highest levels in order to assure that actions consistent with this decision are implemented throughout the entire PCC system. A simple manifestation of such a decision would be greater emphasis on collecting and reporting vital cost, program, and clientele data.

Vital Research Issues

The work to date indicates that there are a number of vital research issues which could be more systematically investigated. Among these questions which need attention are the following:

--What are the costs and benefits of various strategies generally and of particular tactics such as employing clients as staff?

--What are the impacts on the adults and children of the various approaches utilized in comparison with one another, other approaches, and no programs?

--What types of families benefit most from particular strategies (combinations of components)?

--What types of administrative organizations would be optimal in different settings?

--What sequence of activities appears most effective in achieving PCC goals in different environments?

--What approaches to staff training and technical assistance are most effective?

--How can client involvement in program development and operation be achieved more constructively?

--In what settings are the greatest benefits achieved from program investments?

--What really new concepts are emerging that are of potentially broad benefit?

--Are there ways to decrease client turnover or cope more effectively with this problem?

There are obviously many other important questions. This list is merely suggestive. To pursue them, however, does require some modifications of present attitudes and procedures.

Demonstration Procedures

One requirement for a program with a greater research and demonstration emphasis is to involve persons with this type of interest and experience in the program at all levels. Another requirement, frequently mentioned already, is that adequate and accurate records be maintained. Still another is that at least some desired outcomes should be stated in ways that are subject to identification and measurement. Testing and other techniques for measuring status and change should be widely utilized under conditions likely to produce useful results. The consideration of program outcomes cannot be delayed indefinitely and these procedures that permit more systematic assessment should be instituted as soon as possible.

Research and Evaluation Personnel

One of the reasons for limiting research related activities at the outset of programs is the resistance of program participants.

To help deal with this problem it is suggested that research personnel be specially sensitized to the concerns and fears of the participants and that they be trained to conduct their inquiries in ways that are compatible with the participants. Our experience in administering the Bayley Scales indicates that this can be readily accomplished.

PCC as an Operating Program

Administrative Arrangements

A larger and more diverse staff at the national level would probably contribute substantially to the development of the program. While the program is presently not very large in magnitude, it is new, varied, and complex as well as venturing in some unknown areas. While there are dangers of building a large and cumbersome project superstructure, it does appear that staff supplementation would be particularly useful at this time to strengthen resources, especially to deal with the infants' programs, nutrition, community organization, and management aspects of center operations.

At the local level there appears to be an urgent need to simplify the administrative structure imposed on centers. Containing the demonstration centers within the local CAA structure has imposed severe difficulties without compensating advantages. Direct grants to PCC's or to a more well-established organization with a particular interest in family and child development might be an alternative to the present arrangements.

Program Definition

The program has developed to the point that it would be very useful to have more clear-cut and specific guidelines for centers. As indicated in this report, even at this early time it seems evident that some approaches are more effective than others and there is no reason to continue to repeat past errors.

A related need is the development of comprehensive guidelines for infant development in physical, cognitive and social areas that can be used for a variety of purposes (program design, training, etc.). A companion to this should be suggestive guidelines for family development programs.

Program Strategy

Up to this time program strategies have generally been developed at local levels. While this has, in some cases, resulted in programs particularly suited to local needs, in other cases the program approach, the available local resources, and the nature of the clientele have not been effectively related to each other. For instance, day care is rarely provided in urban areas where there are employment opportunities for mothers and often provided in rural areas where such opportunities are rare. The national officials can be of great help in assisting local centers to develop a strategy focusing on which clients to serve, and then selecting a staff and program design consistent with those goals. This approach might prevent the frequent condition which is that the nature of the competence of the director (rather than the needs of the clients) tends to dictate the type of program devised.

Technical Assistance

There is an urgent need to develop a more effective system of technical assistance to the centers. One approach to this problem, as suggested by Dr. Murphy, would be to have traveling teams of consultants work with the center. The team should be composed of members who have demonstrated competence in dealing with the poor, special backgrounds in comprehensive child-care planning, and individual specialties in relevant areas such as health, nutrition, casework, etc. To assure continuity of contact between the technical assistance group and the center, each team should be assigned only the number of centers it can handle comfortably on a continuing basis.

If the proper resource people for these vitally needed teams are not readily available, intensive efforts should be made to identify those with potential for this type of work and to train them intensively for it. This effort should receive high priority. Having only mediocre people or those whose backgrounds are not relevant would be a serious mistake.

Training

It is not surprising that the needs for more and better training are manifest throughout the program. Especially in the infant development field, there is a severe shortage of people. When one adds the other capabilities that would be useful to the program, the supply is minute. It is suggested therefore that training programs be especially and separately devised for center directors, professional staff, nonprofessional staff, PAC members, consultants, and clients. A high training investment is a necessary concomitant of working in new fields with relatively inexperienced personnel.

Dealing with Special Problems

At present there is no method to deal with special problems that may be common to a number of centers. For instance, the problem of staff and clientele turnover needs intensive study and the development of methods to cope with it. It may be that a task force could be constituted for this purpose. Others might be constituted to deal with other particularly difficult and crucial problems that neither national nor local staffs have time to solve.

THE FUTURE OF THE PROGRAM

The program has made worthwhile accomplishments in its start-up phase. It is now appropriate to consolidate these accomplishments, to prepare to learn more systematically from the demonstration, and to take steps to improve the efficiency of the operating phase that is being entered. Maintaining the program at about its present operating size probably affords the opportunity for increased improvement and observation necessary at this stage of the evolutionary process. It will be necessary, however, to provide additional support funds to accomplish the improvements suggested, particularly in training, technical assistance, research and evaluation, health components, and infant development projects. A vastly expanded program would require so much administrative effort that it might be difficult to make the important changes suggested. Decreasing the program is surely unwarranted in view of the early stage in the program's development and great progress made, the benefits of the program, and the enormous need to accomplish what has been started.

There appears to be a great tendency for new, exciting and important programs that are essentially experimental to become staid, bureaucratic, rigid and invested in doing more of the same. It is hoped that somehow it will be possible to maintain the initial vigor and openness, the recognition of how little is known and how much there is to learn. It is hoped also that changes are not perceived as admissions of errors but as opportunities to improve. Finally, since our fundamental concern is with the development of infants and young children, this concern, somehow, should transcend the institutional, professional, and even personal investments of any who are responsible for the design, administration, operation, and evaluation of the program. Let's not forget the babies!

EPILOGUE

Dr. Lois B. Murphy served as senior consultant to this study. A richly experienced contributor to the literature of personality development in the preschool years, Dr. Murphy has been an enthusiastic supporter of and adviser to the national Head Start program. She also served on the Task Force which designed the Parent-Child Centers Program. During the course of this study she visited a rural Parent-Child Center in New England.

What follows are excerpts from a longer evaluative document she prepared for this study. The full document is included in a volume of appendices which has been provided to the programs management. This document was written independently of this report; and Dr. Murphy's conclusions and recommendations are her own, though the reader will note their concordance with many of those of the study.

Curing a Social Cancer

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The purpose of this essay is to comment on the first two years of pilot and exploratory work of the Parent-Child Centers--a program directed to the needs of heretofore unreachable families with babies and children under three.

I am commenting within the perspective afforded by participation in the 1964-66 NIMH workshops on early child care (see Early Child Care: New Perspectives, by Reginald Lourie, M.D., Caroline Chandler, M.D., Ann Peters, M.D., edited by Laura Dittmann), and in the White House Task Force on Early Childhood, 1966-67, as well as experience as chairman of the Kansas Governor's subcommittee on preschool retardation, 1964-65. In addition, I worked as consultant to the North Topeka Day Care Center from 1966 to 1970, spending one day a week with the children and staff for two years, with biweekly or monthly visits the next two years. For a half-century, from childhood, frequent moves and much travel gave me an opportunity to have some acquaintance with the poverty of mountain and rural families living in shacks, tar-papered or dilapidated, the "poor whites" whose "stock had degenerated," and the voiceless Blacks of the South as well as the resentful dwellers of rat-infested Harlem.

I had not seen everything--since getting involved in Head Start and the Parent-Child Centers I have seen battered and neglected children, children whose fathers are in the penitentiary, children of prostitutes and addicts, children with heads crawling with lice, and pale faces pocked with sores and scabs from bites and untended injuries. I have not seen for myself children with parasites, round-worms which have to be pulled from their noses, as observed by certain Parent-Child Center field associates. However, I have seen toddlers leashed to trees, wan babies kept in cribs to an advanced age because the filthy, splintery floors are too unsafe to permit normal exploration at the crawling stage, and others whacked by exhausted mothers too tired and defeated to provide positive guidance at the stage of beginning autonomy. I have seen children winding their way through piles of dirty mattresses and clothing for which there was no storage furniture, and children with conspicuous neurological problems, and others with severe speech defects, with no specialist available within 150 miles.

I have spent four days on two different occasions at one Parent-Child Center, two hours at another, and have read all of the final reports, and a large number of bimonthly reports on the entire group of Parent-Child Centers, as well as participating in planning conferences, training sessions, and other meetings at the national level.

BEFORE PCC

Typical of conditions facing many PCC's are the following:[1]

> By and large, the T. PCC families are the back-alley, side-street residents whose presence the larger community would like to ignore. They are that strange and baffling American phenomenon, the hard-core, depressed poor who as fourth and fifth generation Americans belong to families that have accumulated neither property, education, nor the means for making a livable family income. The men hunt and fish, sleep around the house during the day, and drink with one another at night,

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[1] All quotations are excerpted from bimonthly or final reports of Field Research Associates for the Kirschner National Evaluation. Because of commitments to respect the confidences of the PCC's, all names, initials, places are changed to prevent identification.

> work now and again at odd jobs but never seem to develop the skills currently valued and rewarded by society. The women are sickly, overburdened with children, and condemned to live as prisoners in squalid, isolated shacks. The mothers and children are dirty, unkempt, ill-nourished physically and intellectually, and the schools send the children out into society as semi-literate, unskilled citizens destined to become tomorrow's welfare recipients.
>
> Housing for the poor in T. is bad. Many poor families, Black and White, are crowded into ill-kempt shacks along unpaved roads. Front yards are often turned into dumping grounds for assorted old cars and other junked items. A modern public housing project has recently been completed, but its limited capacity has not removed many families from their squalid living conditions.

We have seen such homes north and south, east and west, in rural areas, small towns, and cities--the homes of destitute children in the U.S.A.

THE PCC CHANGES

Staff

> A year ago this woman, looked and dressed ten years older, had the superficial characteristics of a slightly retarded adult, and spoke in phrases, not sentences, and only when spoken to. Now, a year later, she took her place in this group as a reasonably attractive, neatly groomed, and well-spoken staff representative of the T. PCC.

Changes in the Family and/or Mothers

Self-Concept

> There is no question in my mind that the PCC program has had a most beneficial impact on the mothers. They are dressing better themselves and keeping their children clean and neat. The staff reported that the mothers have become housekeepers, perhaps for the first time in their lives. Being in the PCC program has given new meaning and zest to the mother's life. They

are doing and learning interesting things, and most of all finding out about themselves.

Self-Sufficiency

I think it is clear...that many of the mothers are enjoying improved self-concepts precisely because the program has helped them to be and to think of themselves as more capable and of more self-worth.

Family Structure

In general, participation in the PCC has raised the mother's level of aspiration about what their lives and the lives of their children could be like. This has led some of them to be dissatisfied with their husband's indifference and lack of ambition.

With their increased opportunities to interact with other people, the mothers are actually turning out to be more desirable wives. They have more things to talk over with their husbands and find that they are not as bored with home life as they used to be.

Changes in Parent-Child Relationships

This has been perhaps the most noticeable area in which the PCC has brought about change. Both the staff and the mothers mentioned that they now have to give their children increased attention. The children want them to talk to them and play with them.

Happily, the mothers also report that the fathers are taking more interest in the children.

Changes in Children

There can be little doubt that the PCC program is bringing important benefits into the young lives of its child participants. The mothers stress their improved ability to talk and communicate, their willingness to play and get along with other children, and their increased ability to amuse themselves.

The staff feels that the children are noticeably more active and content than they were at the beginning.

SUMMARY OF THE NEED

Our society is producing a larger number of preventable handicapped. Srole and his associates have documented the greater amount of illness and mental illness in the lower socioeconomic levels. Pasamanick and his colleagues have documented the greater prevalence of inadequate nutrition, prenatal care, delivery care, and care during infancy in the poorest groups, with associated learning, behavior, and emotional difficulties in childhood. National statistics document the high rate of infant and maternal mortality in comparison with other advanced cultures. Many other investigators have given evidence of depressed and disturbed functioning of children and adults in poverty groups. Progress of technology has brought decreased opportunities for employment of unskilled, illiterate workers and a greater need for trained workers who can read. Pressures of increased urbanization make greater demands on integration and control which in turn require better health from the prenatal stage through the entire growth period, and better mental health throughout. The failure to meet these needs has produced a progressive load of pathology, a burden on society, a waste of human potentialities as well as a shock to humane sensitivities and norms of decency. Our affluent society is producing a type and amount of human waste unknown, for instance, in Scandinavian countries with far better infant mortality rates and related indices.

We are familiar with varieties of rehabilitation of war-injured amputees or thalidomide-handicapped children. Here we are dealing with the illness and exhaustion of defeated and depressed parents who produce vulnerable, sometimes damaged, poorly fed, guided, and cared for children.

Moreover, the sense of defeat and hopelessness in the isolated rural pockets, the areas where people had been cast out by disappearing industries or rejected because of race, was generations old.

Parents themselves had grown up in degraded environments. It could be assumed that generations of neglect, cummulative stress, and hopelessness could hardly be "cured" in a year or two. Some experienced observers say five or ten years, others suggest that a commitment over at least a generation would be needed to reverse the degenerative process and establish a healthy process of development.

Thus, the challenge is to develop ways of instigating basic social changes which will reverse the tide of increasing pathology, which will help parents produce and rear healthier babies, better equipped to learn, and to participate constructively in contemporary life. The Parent-Child Center program was conceived, through NIMH and White House Task Force discussions, in order to develop new approaches to meeting these needs, in widely different subculture groups across the U.S.A.

The program, as implemented, tackled some of the most difficult communities of all--in some cases those without effective or available medical, nursing, or social agency resources, or even Head Start; those not reached by food stamp programs implemented by post offices, because they don't write or receive letters; and moreover, in numerous cases those communities (Appalachia, and other mountain-rural areas) where families were isolated, unknown to the professional community, and often suspicious, shy, anxious, resistant, and "unreachable." Houses not only dilapidated but without plumbing or even nearby water are familiar to those of us who have visited and explored these areas.

Since many of these families had not been reached by other programs, an urgent need was for pilot, exploratory efforts as these could evolve from indigenous trial and error. From Head Start and other poverty programs it had already been learned that local neighborhood people could often reach the isolated poor far more successfully than middle-class professionals--the former could respect the struggles of the poor, speak their language, and respond to their most urgent needs. This has proved to be true in the Parent-Child Centers as well.

Moreover, since widely different geographical and subculture areas were involved, it was assumed that no centrally-planned, uniform program would be likely to fit: individual programs would have to evolve from the needs, personal values, coping capacities, and community resources, and this is what happened.

Assumptions

My evaluation of the first two years of the Parent-Child Centers also assumes that any new program undertaken to meet needs which persist because of the inadequacy of existing social structures must take time, must involve many trial flights, must evolve by a series of gradual steps just as any technological program (such as the rocket-to-the-moon program) evolves. Moreover, the Wright brothers had not gone very far in the first two years of their 13-year effort to get a flying machine off the ground.

The benefits of any pilot program must be measured in terms of the scope of the need, and the potential effects (often hard to determine) at a later point in time. In this case, we are thinking of the social and economic saving over the lifetimes of the children who are saved from dependency on or destructiveness to society and also the social and economic contribution of released capabilities and creativity. Even the small group of the Skeels-Skodak study in Iowa in the thirties has shown how saving a dozen children from early retardation saved the state hundreds of thousands of dollars of cost of custodial care over the lifetimes of this group. We are talking here about savings in welfare payments, special education, state institutional care, destructive delinquency, and many other costs necessitated by the failures underlying prematurity, illegitimate dependent children, inadequate nutrition, disorganizing environments in infancy and early childhood, and lack of stimulation adequate for basic cognitive development and support of a drive to learn.

OVERVIEW

On my global rating from A to F, the large majority of Parent-Child Centers received A+ to C, with 20 percent receiving D to F. The latter included chiefly urban centers plagued by bureaucratic delays, conflicts, and pressures from the hierarchical structures under which they struggled rather unsuccessfully to achieve some autonomy; and those where consultants--Project Advisers and University Affiliates--were totally inexperienced in dealing with poverty groups and were rigid, patronizing, didactic in approach, or power-hungry, domineering, and intrusive.

This observer feels that funding through some demonstrably competent independent authority such as a church or settlement house could be more successful. However, the latter are often disillusioned with the traditional insecurity, temporary commitment, and intrusiveness of federal support, along with the heavy load of paper work, and are therefore hesitant to accept a federal grant.

What a PCC Does: The V. Center

> There are twelve Family Aides who have seven or eight families, each of whom they work with each week. They spend half a day with each family at their home or at a center.
>
> The Outreach Specialist has been much commented on by all visitors. His knowledge of the families to be served (of which he was one) was a major factor in the great speed with which the program got started. His knowledge of the community has also been invaluable in meeting practical needs of the families. As head of the salvage committee he collected stoves, sinks, heaters, building materials, etc. for the use of the Parent-Child Center families. He would go at any time of day or night to help a family with a critical problem.
>
> The Parent-Child Center has been actively involved in SHARE, cultivating seven acres of potatoes on donated land and running a child-care and stimulation program on the cooperative harvest days (as many as 40 adults participated simultaneously).

In the early stages of the program, many of the isolated, deprived mothers living in dilapidated houses without plumbing had needs that were so great that when the aides visited and wanted to engage in stimulating activities with the infants or children, the mothers seemed jealous of this lost attention. This caused the aides to feel considerable frustration about not being able to do the job which they saw themselves as hired to do. At some periods they tried to visit in pairs so that one could work with the mother while the other worked with the child or children. As they have really made progress in solving reality problems of the families, the mothers are more able to tolerate the focus on the children. The aides are thrilled to find many of their mothers really beginning to take pleasure in their children's accomplishments.

Some 30-40 percent of the fathers are involved in the program. Some of the fathers have gotten into Mainstream training programs through the Parent-Child Center. One has become a full-fledged carpenter. There are also social activities which the Policy Advisory Committee organized and which the fathers participate in.

This is the first time that the public health nurses have ever been involved with these families. One of the public health nurses, in connection with some university work, has started prenatal groups in many of the communities served by the V. Parent-Child Center. Family planning is one of the topics that has been popular for meetings.

Outcomes

It is not specific programs, arrangements, or services that would seem to distinguish this Parent-Child Center. Rather it is an overall atmosphere, a high degree of willingness to explore everything that could make living better for their families, an enthusiastic belief in what they are trying to do that makes the V. Parent-Child Center both unique and successful.

The churches who provide space for subcenters donate it. They now see something to do other than dole out an occasional holiday dinner or toy.

Families who previously were simply defeated and unable to make use of the available resources have been shown that there are resources available. If this program continues for very much longer, I cannot imagine these parents being content to settle back into their old patterns, especially as this refers to expecting nothing from the larger society. For this group, whose mothers belonged to the group which has been characterized as "unreachable," this would seem to be a major accomplishment. It has a major impact on the lives of these children.

Unfortunately the experience of this center doesn't translate easily into guidelines for starting new centers. Some possible extrapolations are: choose an area not too large or too cluttered with power struggles between organizations; choose a director with great enthusiasm; have a staff that is as much a part of the community as possible; choose staff more on the basis of human qualities than formal background; and provide as much training at an appropriate level as possible.

PROBLEMS

Physical Facility

The problems with the physical facility have been multiple and are continuing.

Control of the Program

The single most serious problem these centers have experienced has been posed by the CAA director in his determination to gain control over the Parent-Child Center program. Attempts to solve this problem and work out differences have detracted significantly from the PCC program, in terms of staff time, project funds, relations with participants, as well as general worry and strain.

Technical Assistance and Consultation

Unknown to the PCC staff, expertise of the kind they wished for hardly exists, and there is no reason to lament that improvisation was the rule in those days of crisis and chaos.

> Consultants should simply confess that they know far less than their positions warrant; the relationship between experts and locals can and ought to be far more nearly equal than it is now. If there are to be research projects and much traveling about, much would be gained by having the locals do research on the experts once in a while, and by having far more conferences of poor people, with a few invited guests from among the social scientists.

THE MODEL FOR EVALUATION

Any cost-benefit model of a program for people must focus on long-term effects and weigh the costs of rehabilitation against the costs of illness, dependency, and crime over their lifetimes; it must study the range of effects for given individuals; the spread or ripple effect among individuals, including effects on attitudes, insight, current and future behavior of persons influenced by the target persons, and effects on institutions which may more successfully prevent the problems in the future.

The model should also analyze factors and conditions conducive toward or interfering with success of a given program, transfer possibilities and factors reducing transfer possibilities. Finally, the model should weigh costs of the pilot stage against expected costs of later stages and also weigh costs of the program against current costs of the conditions which the program aims to prevent. This includes the costs of welfare, institutionalization, and other sequelae of abject poverty.

Since the present PCC's are so new and so young, it is obvious that long-term continuation and follow-up is necessary:

1. to analyze the factors and steps involved in effective as compared with ineffective PCC's. In a sense, the existence of a wide variety of PCC's makes possible a rough set of comparison groups which can be studied to provide hypotheses to be tested more systematically later.

2. to study the extent to which families and communities are able to maintain the improved level of functioning.

3. to study the development of the children who have experienced improved care as compared with control children still growing up in destitute conditions.

4. to study additional new developments for improving child care and family life.

The comments here are intended simply to summarize some of what we have observed and learned from the first two-year effort.

Tentative Results

Aides

Significance of learning and personal development in the aides: most centers report the aides' satisfaction in their training for work with the children; and some report their progress and satisfaction in training as paraprofessional social workers for work with families, and as nurses.

This involves for all the centers a substantial number of persons who came from poverty themselves, and whose increased skill and competence qualifies them for salaried work in communities where employment is available, and/or progress "up the career ladder." Unfortunately, most centers report that the community in which the PCC is located does not provide opportunities for advancement.

As a related benefit, professional staff, consultants, and field research associates frequently report how impressed they are with the wisdom, resourcefulness, intuition, and skill of some of the aides coming from low-economic groups. Obviously there has been (and still is in many areas with no such programs) a serious waste of human talent when such people are isolated from opportunities to use their gifts for constructive social action.

Mothers

Mothers' improvement in self-image, self-respect, appearance, hopefulness, and skill has been reported wherever PCC's have been successful. They have begun to enjoy their children, to be more constructive in handling them, to talk with them, play with them, help them to learn how to use play materials and other objects, as well as to keep them clean, serve them better food, dress them more adequately, maintain better home routines and medical care.

Shopping trips, tours of agencies, and field trips to get acquainted with the environment have been enjoyed by parents in one center. Parents have been encouraged to form baby-sitting pools to permit more adult outings, and occasional training sessions in "community organization" have been provided in a few centers.

Mothers have most often welcomed classes in sewing, cooking, nutrition, consumers' problems, cosmetics and self-care, child development, family planning, and health. Also, they have studied for GED examinations and attended other basic education classes.

Some mothers have become aides and others have obtained employment which provided better economic support for their families. At one PCC, however, the staff felt that leaving the children to go to work was disadvantageous for the children and discouraged this.

Most impressive was the loss of passivity, discouragement, feelings of hopelessness, disorganization, helplessness, and isolation characteristic of so many mothers before they entered the program. In most PCC's the mothers welcomed the PCC as a place to go, an opportunity to talk to other mothers as well as aides and other staff, to share their problems, along with the opportunities to get help with those problems. They enjoyed and responded to opportunities to attend morning coffee klatches, picnics, holiday get-togethers, recreation (cards, pool, potluck dinners), and other social events; also educational films and demonstrations; and rummage sales as well as home repair sessions.

Children

Children were almost uniformly reported to become more active, outgoing, friendly, happy, talkative, and skillful, as well as better-dressed, cleaner, and healthier. Much improvement has been reported in "relations with children" and "interest in the child's development" on the part of the mothers.

In one center, four non-thriving babies were referred by a local doctor; the PCC set up an infant day-care room, "and we fed them and loved them and they began to thrive and grow."

One center developed a special program with detailed guidelines for work with two-year-olds; since there is such a dearth of such guidelines for infants and children up to the age of three, this could be a contribution to a library of resources for work with young children. Much more is needed in this area.

"A great increase in the use of resources and concern for babies in low-income families" has presumably contributed to the greater interaction between small children and adults.

Other Family Members

Several PCC's have made older children welcome and some have provided special activities after school.

--Some PCC's have offered employment counseling sessions which have attracted both teen-agers and fathers.

Total family involvement has been the emphasis of certain PCC's:

> It would seem that the staff of this PCC has emphasized wisely from the beginning of the PCC effort "maximum feasible involvement" of adults and of total family units. There has never been any such approach as "you bring your children over and we'll 'develop' them for you." Rather, the PCC staff has made a major and fruitful effort at enhancing the total family's social functioning along with a largely center-based effort at cognitive stimulation for infants; in some ways, this latter effort appears to have been secondary during the first, "organizational" phase of PCC life. In a real

> way, the staff have functioned as ombudsmen during the first year, perhaps more than they have as child development specialists. "Zuerst fressen dann die Morale," might have been their motto.
>
> The staff has worked diligently at making families and especially parents feel "at ease" in the centers. The socialization needs of mothers and older siblings have been a (not the only) paramount concern of the PCC staff in working with families which in the main have been isolated from the main stream of life in this largely rural small town area.

Community Effects

Stimulation of community agencies to respond to the previously neglected families is implied in the review of cooperating groups. But in some cases, surprising efforts by the community have been made as in T.:

> While the T. community has been without the resources to offer the PCC much support in terms of professional services, its businessmen and merchants have been relatively generous in supplying the program with in-kind donations. In this fashion the program has received both reduced prices on materials and supplies as well as outright contributions. The county commissioner arranged for the use of prison labor to help with the painting and redecoration of the center. And the contractors who installed heating and other equipment, as well as those who did the major building renovations, worked for less than their usual margin of profit. Vocational Rehabilitation Services provided the program with the volunteer services of one of their clients, and in recent months students from a nearby college have been donating their time as volunteer tutors in a basic education program for the parents.

Factors in Success of PCC's

Factors contributing to success include the warmth, sincere respect for and faith in the potentialities of the poor, dedication, flexibility, and understanding of the staff, including the aides.

Along with these qualities, freedom from rigid, academic, didactic educational and guidance methods; freedom from dictatorial behavior to staff; freedom from competitive, power-hungry, or domineering approaches in the PAC, as well as with the PCC staff, were crucial. Wherever the domineering interference appeared, PCC morale waned, conflicts developed, and progress was blocked. Both directors and field research associates commented that "University professors seldom can speak to the poor in language they can understand," and more than one field associate commented, "Most consultants, University Affiliates and other professionals I have observed seem quite unable to communicate with and relate to untrained staffs." One field research associate suggested that a certain outstandingly helpful consultant be used to provide supervised training for other consultants.

The most outstanding PCC's had enthusiastic directors who encouraged the ingenuity and creativity of their staff, and warm supportive Project Advisers and consultants who provided constructive demonstrations and guidance. Above all they had tolerance for frustrating complications, problems, and confusions.

Another major factor in success has been the response and cooperativeness of the larger community. In some instances, churches, schools, hospitals, clinics, city, county, and state health and social agencies, well baby clinics, public health nurses, private physicians and dentists responded generously to the needs presented by the PCC. In other instances, distance, lack of resources, overloaded and underfinanced hospitals and clinics, or competitive attitudes or biases, or disagreements about procedures have interfered with potential progress. In some instances initial conflicts have been worked through, with resulting extension of community cooperation and support.

In several isolated PCC areas, providing transportation to take children or parents to the available clinic or doctor has been a necessary solution and this has involved both the purchase of a bus and use of staff cars.

> Not all relationships have been smooth and conflict-free, however. In two counties of the PCC area there have been rather frequent clashes with the county welfare offices over public assistance administration policies and there have been sharp conflicts in some townships with township bodies which refused to introduce the food stamp programs into their locales.

Factors interfering with success have been implied above. Others include text-bookish or too technical training by trainers who were not experienced with children under three, or with poor families; lack of spontaneity and interest on the part of staff, inappropriate programs for the children, and even the mothers when they were unwed teen-age mothers. For instance, in one center a staff member was observed to attempt to read to two- and three-year-old children as if they were four-year-olds, "and the result was near chaos;" and "lessons" were followed rigidly and without skill in engaging the children's interest.

Intrastaff conflicts, interagency conflicts, power conflicts in the community; interference, blocking, and noncooperation from the granting agency all interfered in certain instances.

Unsolved transportation problems, low effort, lack of imagination in staff interfered in other cases.

One observer reports that "No one profession is adequately prepared to provide consultation and in-service training for PCC programs....The interrelatedness of various skills is frequently ignored and the contribution of health to mental development is given lip service."

The comprehensiveness of PCC goals requires the development of new multipurpose professional staff with interdisciplinary training as well as training in the kinds of support infants and children need for total development. Further discussion of this point will be provided shortly.

Emerging Principles

Changing helplessness, hopelessness, squalor and destitution of isolated families involves a series of steps:

1. Reaching the heretofore unreached or "unreachable."

2. Activation of hope and a capacity for effort.

3. Skill-development in aides and parents: health, nutrition, homemaking, child-rearing skills, etc.

4. Social involvement, stimulation of a capacity for pleasure in being with others, communicating, and cooperative action with others in the community.

5. Correction of unhealthy, depressing, home conditions and environment.

6. Stimulation of children through:

   a. interaction, play equipment and materials, group experience with other children;

   b. providing intrinsic stimulation through improved housing so that babies can crawl, explore, learn to walk;

   c. demonstrations of enjoying babies, responding to their initiative and cues, thus providing intrinsic social reinforcement of coping efforts and cognitive and social development;

   d. development of mother as a more stimulating object.

7. Job preparation and finding better jobs, with resultant better economic resources.

8. Increased self-respect, improved self-image, responsiveness and coping capacity.

PCC's may and do undertake this sequence successfully under certain conditions:

1. A PCC, because of the newness of its character, requires supported autonomy, not hierarchical interference by a superstructure of bureaucratic organizations.

2. A PCC needs an enthusiastic and effective director who can evoke a sense of dedication from the staff sufficient to weather inevitable setbacks.

3. A PCC needs to recognize priorities: there are limits to a mother's ability to help her children when home conditions are miserable and she is exhausted from struggling with them.

4. A PCC needs help, in training staff, from flexible professionals who can respond to the clients' level of communication, needs and interests.

These consultants should also be creative in adapting their training (from social work, Montessori or other cognitive stimulation, nursing, etc.) to the needs of the clients. This has been done with drop-in consultations, group discussions, home visits by nurses and social workers and other methods of meeting poor families more than halfway, or reaching out the whole way.

5. PCC staffs need to appreciate what they can learn from the poor as well as what they can teach them. This happens naturally when aides become "Family Friends," visiting with mothers on a par, sharing observations, not dictating procedures.

6. Training has used example and demonstration, with films and audio-visual aids, supervised practice, use of illustrative posters and bulletin boards, observation of family learning needs in their homes.

7. Materials and equipment suitable for infants and small children have been devised.

8. A PCC that attempts to meet crisis needs and urgent priorities needs to have some portion of staff available or "on call" 24 hours a day. Such staff need to be sensitive to what the parent can do for himself, and how to furnish just enough assistance to evoke the strengths and resources of the parent. This may involve, as in one instance, helping to arrange for a parent to pay a debt in small steps, or taking the parent to a doctor's office when other

transportation is not available, or offering to help with work on home repair if the parent will do his share, and so on. This kind of flexible support has required imagination and constant ad hoc problem solving by aides, adapted to maximizing what the parent can contribute.

9. A PCC thrives when the staff members "make the centers belong to the families," and support increasing democratization and autonomy in local PCC's.

10. Most successful PCC's develop flexibility in role: "No one has a completely 'hands-off' of infants assignment. Rather, intermingling of functions by all staff contribute to a warm and stimulating environment for the children."

11. Most PCC's successful with isolated, destitute families have utilized visits in the homes, often with interested responsiveness to the family as a whole. Providing the mother with a sympathetic listener often seems to be the key to further involvement in the PCC and her activation results in greater spontaneity and interaction with her children.

12. Community distrust, misinformation, and stereotyping has been reduced by open houses, free access to the press, and by newsletters, as well as by widespread cooperation and communication with other civic organizations and agencies.

13. While many PCC's have made good use of community contributions of clothing, appliances, furniture, and of training in remaking clothes for children from partially-worn adult clothes, money is needed in the budget for paint, materials for house repair, and furniture, shelves, etc. that the family can make.

14. Most important is the expectation that people can change. This in itself requires changes in attitudes of staff who themselves may have believed that destitute people were that way because they were "shiftless," or "have always been that way."

15. Lifting the morale, and level of family life, activating the family, stimulating communication between family members, all contribute to a better and more stimulating environment for the infant and young child.

Variety of Programs and Potential Models

Programs have differed partly by design, also in response to differing needs of different subculture and ethnic groups, age level, family structure of client groups, and also their housing, health, and location in respect to the PCC and other facilities. Programs have also differed as a result of different capacities and personalities of directors, relation to PAC's, CAA's and to community resources and administrative structure, and finally, the helpfulness of consultants, Project Advisers and University Affiliates.

At this stage it seems unlikely that we could state totally objective criteria for selection of "a model" from among these varied programs as they have evolved from the varying needs of widely different areas. Moreover, selection of models will be influenced by the human values of the individuals or groups who do the selecting. Shall we select models from those PCC's that had the most responsive clients who were most "ready for" and receptive to the help offered? If so, we can eliminate the models developed in the most isolated areas where the poor were anxious, shy, suspicious, or in other ways resistant to early approaches and required the most time, patience, flexibility, and resourcefulness of the staff.

Or shall we say that this group of hard core "unreachable" families and their children need help most and should have high priority? If so, we shall emphasize empathy, tolerance, ingenuity, a capacity for direct meeting of the most urgent needs first--whether these are getting the worms out of the children, the rats out of the kitchen, cleaning the "shit off the floor," repairing a broken sewer, or finding a house with running water and an indoor toilet for a family without these decencies.

By contrast we might select a model with an eager clientele and ample available and cooperative community resources. We might then design a pattern from these to provide adequate family planning, marital and genetic counseling, prenatal care, delivery and infant care; skills to parents; social opportunities and so on.

Such a model could make a contribution through developing ways of helping parents to understand the crucial importance for later development of: a healthy, sound, physique without defects or undernourishment; freedom from stress and upheaval in the early months when perception, cognition, and basic relationships are developing; and interaction with the environment both of impersonal objects and of persons. At present we do not have comprehensive guidelines for support of cognitive, emotional, and social development in the first three years.

Another aspect of model-building is concerned with the degree of centralization of the PCC. In at least five PCC's now meeting needs of families widely scattered over rural areas with inadequate or no public transportation, two to six small centers have been located at strategic points in order to serve the largest possible group. This facilitates focusing on the different needs of individual subcenter areas, which may vary as much as certain major geographical or ethnic groups differ from each other.

Finally, it seems evident that encouragement of the evolution of the PCC from the needs and efforts of the parents themselves has been the key to success in most effective PCC's and is the foundation for any model. If this is granted, PCC's will inevitably vary, in relation to the needs and resources of each local area.

A model then, can at best be only suggestive and must be flexibly responsive to changing needs as the clientele develop.

Further development of PCC's requires:

1. development of more potential directors with interdisciplinary training, flexibility, and capacity to support creative

problem-solving as well as empathy and respect for the poor and staff.

2. development of comprehensive guidelines for infant development in physical, cognitive, and social areas.

3. development of suggestive guidelines for family development in all areas.

4. flexible allocation of counseling resources from Washington to those PCC's that urgently need help in the period of organization.

5. a traveling team or teams of consultants with demonstrated competence in working with the poor; with the special competence required for comprehensive early child-care planning; and with multiple know-how resources to stimulate constructive problem-solving efforts in all areas.

APPENDIX A

STAFF INFORMATION

TABLE A-1: PARENT-CHILD CENTER PROGRAM: TERMINATION OF STAFF

TABLE A-2: PARENT-CHILD CENTER PROGRAM: PAID STAFF

TABLE A-3: STAFF ACTIVITY REPORT

TABLE A-1

PARENT-CHILD CENTER PROGRAM: TERMINATION OF STAFF

(In Percents Based on 1,041 Staff Employed to date and 287 Terminated)

	Percent*
1. Total Paid Staff Employed	
A. Terminated	27
B. Now employed	73
2. Termination of Staff by Position held:	
A. Administrative	6
B. Other professional	16
C. Paraprofessionals	60
D. Clerical	12
E. Semi-skilled	6
F. Not reported	0
3. Reason for Termination:	
A. Temporary position	22
B. Left for new job	19
C. Personal reasons	30
D. Administrative problems	7
E. Health	7
F. Negligence	3
G. Other	7
H. Not reported	5
4. Number of Months Employed	
Less than 3	33
3 - 4	18
5 - 6	15
7 - 9	15
10 -12	6
More than 12	2
Not reported	11

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE A-2

PARENT-CHILD CENTER PROGRAM:
PAID STAFF

(In Percents Based on 702 Staff Paid by PCC
and 52 Paid by Other Agencies)

	% of Staff*	% Centers Employing*
1. Job Title		
Administrator	13	97
Social Worker	2	37
Teacher	3	31
Home Economist	1	20
Child Development Specialist	2	29
Nurse	4	57
Psychologist	2	20
Speech Specialist	1	6
Nutritionist	0	0
Social Worker Aide	17	69
Teacher Aide	15	66
Parent Educator	4	31
Nurse's Aide	1	23
Center or Program Aide	11	66
Tutor	0	3
Day-Care Mother	4	9
Infant Educator	2	9
Clerical Worker	10	97
Cook	3	34
Maintenance Worker	3	43
Transportation Aide	2	37
Other	1	20
Not Reported	0	0

	% Currently Employed*	% Terminated*
2. Job Category		
Administrative	10	6
Professional	15	16
Paraprofessional	57	60
Clerical	10	12
Other	8	6
3. Status of Employment		
Full-Time Paid	62	
Part-Time Paid	18	
Volunteer	20	

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*In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE A-2 (Continued)

	% Currently Employed	% Terminated
4. Number of Hours Worked per Week		
Less than 4 hours	0	
5 - 9 hours	1	
10 -19 hours	5	
20 -29 hours	11	
30 -40 hours	71	
Over 40 hours	5	
Not reported	7	
5. Age		
Less than 19 years	6	15
20 - 24 years	19	28
25 - 34 years	33	31
35 - 44 years	21	14
45 - 54 years	11	4
Over 55 years	7	3
Not reported	3	5

	% of Staff Currently Employed	% Terminated	% of Centers Employing
6. Ethnicity			
Mexican-American	7	7	14
Puerto Rican	1	1	9
Other Caucasian	36	41	86
Negro	42	32	80
American Indian	5	8	11
Oriental	1	1	6
Eskimo	1	2	6
Polynesian	1	1	3
Other	3	4	37
Not reported	3	3	
7. Sex			
Male	13	18	
Female	87	82	
8. School Years Completed			
None	0		
1 - 4 years	1		
5 - 8 years	14		
9 -10 years	13		

TABLE A-2 (Continued)

	% of Staff Currently Employed	% Terminated
11 -12 years	31	
1 - 2 years of college	15	
3 - 4 years of college	12	
Over 4 years of college	11	
Not reported	3	
9. Highest Level of Education Completed		
None	1	3
Elementary	23	26
High School	42	38
Bachelor's Degree	11	14
Master's Degree	7	6
Doctor of Dental Surgery	0	0
Doctor of Medicine	0	0
Other Doctorate Degree	1	1
Registered Nurse	3	2
Other	5	3
Not reported	7	8
10. Degree Major		
Education	5	
Home Economics	2	
Psychology	4	
Sociology	1	
Social Work	2	
Science	0	
Liberal Arts	1	
Other	6	
No Degree	78	
Not reported	1	
11. Previous Experience in a Poverty Program		
Yes	37	31
No	55	63
Not reported	8	6
12. (If yes to #11) In Which Program:		
Head Start	28	11
Other CAA only	11	3
Other OEO only	22	8
Other only	22	6

TABLE A-2 (Continued)

	% of Staff Currently Employed	% Terminated
Experience in two	11	2
Experience in three	3	1
Experience in four	3	0
13. Job Titles of Previous Positions Held (by percent of staff reporting in each category):		
Administrative, Managerial	14	7
Teacher, Educational Specialist	16	11
Teacher Aide	15	11
Social Services Professional	9	8
Social Services Aide	8	7
Medical Professional	6	3
Paramedical	7	5
Child-Care Worker	15	10
Nutritionist	3	2
Cook	9	7
Secretary, Clerk	19	17
Maintenance Worker	8	5
Transportation Aide	5	5
Other	23	25

	% of Staff Currently Employed	% of Centers Providing
14. Training received through the PCC in the following (by percent of staff and centers reporting in each category):		
Orientation to Center Program, Goals, Policies	60	97
Techniques for Working with Low-Income Families	40	91
Orientation to Community Resources	42	94
Orientation to other Poverty Programs	39	97
Infant Care and Development	40	94
Child Care and Development	41	97
Psychology of Infants and Children	26	91
Adolescent Psychology	10	71

TABLE A-2 (Continued)

	% of Staff Currently Employed	% of Centers Providing
Counseling with Adults	19	77
Preschool Educational Techniques	26	91
Teaching or Tutoring Children	18	74
Teaching or Tutoring Adults	10	51
Employment Counseling, Job Development	11	37
Home Economics, Consumer Education	20	77
Health Care, Nutrition	29	94
Recreational Work with Families	14	83
Clerical Training or Procedures	11	74
8-Week University Sponsored Head Start Training Program	2	29
5-Day University Sponsored Head Start Orientation Program	4	34
Adult Education or Extension Courses	10	60
Other	12	71
No Training	31	

15. If Adult Volunteer, indicate whether:

Regularly employed elsewhere	21
Voluntarily unemployed (retired, wives, etc.)	37
Involuntarily unemployed, seeking employment	5
Involuntarily unemployed, not looking for employment	3
Not reported	34

	Annual Family Income	Annual Salary Paid by PCC % Currently Employed	 % Terminated
16. Annual Family Income			
Under $ 1999	3	6	13
$2000 - 2999	3	4	7
$3000 - 3999	9	24	18
$4000 - 4999	9	16	12
$5000 - 5999	9	10	4
$6000 - 7999	11	11	7
$8000 - 9999	8	7	7
$10,000 and over	16	4	3
Not reported	32	17	28

Mean number of Wage Earners in Family: 1.5

TABLE A-2 (Continued)

	% Currently Employed	% Terminated
17. Source of Income		
Wages	83	
Public Assistance	6	
Social Security or Other Pension	4	
Other	7	
18. Related to Child in the PCC Program		
Yes	19	16
No	75	69
Not reported	5	7

	% of All Staff	% of Staff Related to PCC Child
19. Relationship to PCC Child		
Mother	13	65
Father	2	11
Other adult relative	3	0
Older sister or brother	0	0
Other school-age relative	1	5

	% Currently Employed	% Terminated
20. Reside in Neighborhood near Center		
Yes	60	63
No	35	37
Not reported	5	0
Range of staff residence near center 0-94		
21. Fluency in Language		
English	77	
Spanish	12	
French	4	
American Indian	3	
Hawaiian	0	
Other	4	
22. Language used with Children in Program		
English	86	
Spanish	10	
Other	4	

FORM A-3

Instructions
NATIONAL PARENT CHILD CENTERS STUDY

Kirschner Associates, Inc.
11716 West Pico Boulevard
Los Angeles, California 90064

The Staff Activity Report should be completed by all staff and volunteers working with the PCC. The form asks for a summary of your activities for the coming week. The information will be collected twice during the year and will be used to describe the range of activities and services provided by all the Parent-Child Centers. It is important to list all the different kinds of services and activities in which you are engaged so that a complete description of the PCC program can be made.

In Section A. please list your services or activities, the number of hours spent during the week in each of the activities, and the number of clients participating in the activity. Listed below are a variety of ways of describing various aspects of PCC work. It is meant merely as a guide, and you are not limited by the activities on this list.

Baby sitting
Emergency Child care
Play group for Infants and Toddlers
Play group for other preschoolers
Infant Cognitive Stimulation
Academic classes for parents
Vocational classes for adults
Family Life Education
Child Development classes
Health Care classes
Home Management classes
Consumer Education classes

Medical Services
Family planning services
Visiting nurse services
Individual Counseling
Group Counseling
Transporting Family

Homemaker service
Repairing homes
Serving meals
Picnics, outings
Movies at Center
Recreation at Center

Finding referrals
Making referrals to other agencies
Employment counseling
Housing referral
Legal services

Section B. asks for the total number of hours spent during the week in meetings with various individuals or groups.

Section C. asks for the number of hours spent in travel, record keeping, program planning or staff training.

When you have completed this form at the end of the week, please return it to the Data Coordinator at your center.

Thank you

FORM A-3

STAFF ACTIVITY REPORT

Name________________________________ Center________________________________

Position________________________________ Week Of: ____________________ Total Hours Worked this week:__________

INDICATE NUMBER OF PERSONS PARTICIPATING IN EACH ACTIVITY

A. LIST ACTIVITY OR SERVICE	Hours spent at this task	Children Under 3	Other Children	Mothers	Fathers	Whole Family

B. Number of Hours spent this week in meetings with:

_______Consultants

_______PCC Staff

_______PAC or other Committees

_______Other Agencies

_______Community Groups

C. Number of hours spent this week in:

_______Travel

_______Inservice training

_______Program Planning

_______Report writing, record keeping

_______Other, specify

APPENDIX B

FAMILY INFORMATION

TABLE B-1: PARENT-CHILD CENTER PROGRAM: TERMINATION OF SERVICE TO FAMILIES

TABLE B-2: PARENT-CHILD CENTER PROGRAM: INFORMATION ON FAMILIES

TABLE B-1

PARENT-CHILD CENTER PROGRAM: TERMINATION OF SERVICE TO FAMILIES

(In Percents Based on 2,426 Families to date, 1,818 Families Currently Served)

	Percent*
Total Families Served	
Terminated	25
Now Served	75
Range of Families Terminated in PCC's	0-47 (Varies)
Total Focal Children Served	
Terminated	25
Now Served	75
Number of Months in Program Prior to Termination	
Less than 3 months	43
4 - 6 months	25
7 - 9 months	13
10 -12 months	5
More than 12	2
Never attended	7
Not reported	5
Average number of months of service: 3.8	
Reason for Termination of Family	
Family moved	38
Family uncooperative	25
Mother employed	17
Family over income	2
Child over age	11
Other	3
Unknown to Center	2
Not reported	3
Person Responsible for Decision to Terminate Family	
Center Director	19
Other Staff	20
Client	55
Other	5

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE B-1 (Continued)

	Percent
Comparison of Present with Past Employment Status: Male Head of Household	
Unemployed at Intake, Now Employed	4
Employed at Intake, Now Unemployed	3
Employed at Intake, Still Employed	44
Unemployed at Intake, Still Unemployed	6
Not Applicable	37
Not Reported	5
Comparison of Present Income with Income Prior to PCC Enrollment	
Income Increased between Intake and Termination	11
Income Decreased between Intake and Termination	5
No change in Income	66
Not Reported	17

TABLE B-2

PARENT-CHILD CENTER PROGRAM: INFORMATION ON FAMILIES

(In Percents Based on 1,818 Families, All Information at the Time of Intake to the PCC)

	Percent*
1. Focal Children Served	
Number of focal children in program per family	
One child	65
Two children	28
Three children	6
Four children	1
2. Age of focal children at intake	
0 - 5 months	17
6 -11 months	14
12 -17 months	15
18 -23 months	16
24 -29 months	14
30 -36 months	12
Over 36 months	10
Mean age: 19.4 months	
3. Sex of focal children	
Male	51
Female	47
Unborn	3
4. The Families	
Puerto Rican	1
Mexican-American	8
Other Caucasian	27
Negro	47
American Indian	11
Polynesian	2
Oriental	0
Eskimo	1
Other	2
Not Reported	1

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE B-2 (Continued)

	Percent
5. Public Welfare Status	
Yes	42
No	53
Not reported	5
Range of families on welfare for Centers	5-77
6. Is father living in home	
Yes	58
No	42
Range of families reporting father living in home for Centers	20-91
7. Age of father living in the home	
Under 21 years	6
21 - 34 years	62
35 - 49 years	28
50 - 64 years	3
65 years and over	1
8. Education of father*	
None	1
1 - 3 years	4
4 - 6 years	10
7 - 8 years	24
9 -11 years	30
High School Graduation	22
Some college	4
College Graduation	1
Not reported	4
9. Occupation of father*	
Professional, technical and kindred	1
Farmers, and farm managers	1
Managers, officials, proprietors	1
Clerical and kindred workers	1
Sales workers	1
Craftsmen, foremen and kindred workers	4
Operatives, and kindred workers	5
Private household workers	30
Service workers	37

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* Includes natural father, stepfather, foster father or man acting in role of spouse.

TABLE B-2 (Continued)

		Percent
	Farm laborers and foremen	0
	Laborers, except farm	3
	Student	1
	Armed Services	4
	Retired, disabled	3
	Not Reported	11
10.	Current employment status of father	
	Employed	72
	Unemployed	26
	Not reported	2
	Range of fathers unemployed for Centers	0-59
11.	If father is not now employed, what is the reason:	
	Could not find work	35
	No transportation to work	1
	Ill health	24
	Did not seek employment	3
	Other	27
	Not reported	12
12.	Number of months father was employed last year:	
	12 months	49
	7 -11 months	20
	4 - 6 months	12
	Less than 3 months	13
	Not reported	6
13.	Is mother living in the home:	
	Yes	99.7
	No	0.3
14.	Age of mother living in the home:	
	Under 21 years	21
	21 - 34 years	56
	35 - 49 years	12
	50 - 64 years	0
	65 and over	0
	Not reported	12

TABLE B-2 (Continued)

	Percent
15. Education of mother	
None	0
1 - 3 years	1
4 - 6 years	5
7 - 8 years	22
9 -11 years	40
High School Graduation	22
Some College	4
College Graduation	0
Not reported	5
16. Occupation of mother	
Professional, technical and kindred	1
Farmers, and farm managers	0
Managers, officials, proprietors	0
Clerical and kindred	1
Sales workers	0
Craftsmen, foremen, and kindred	0
Operatives and kindred workers	1
Private household workers	1
Service workers	9
Farm laborers and foremen	0
Laborers, except farm	1
Housewife	81
Student	2
Not reported	3
17. Current employment status of mother	
Employed	14
Not Employed	84
Not Reported	2
Range of mothers not employed	36-100
18. If mother not now employed, what is the reason	
Could not find work	7
No transportation to employment	0
Ill health	2
Did not seek employment	40
Other	30
Not reported	5
Not applicable	15

TABLE B-2 (Continued)

	Percent
19. Number of months mother was employed last year:	
12 months	6
7 - 11 months	5
4 - 6 months	8
Less than 3 months	65
Not reported	16
20. Annual Family Income:	
Under $ 1999	19
$2000 - 2999	16
$3000 - 3999	13
$4000 - 4999	7
$5000 - 5999	5
$6000 - 7999	4
$8000 and over	2
Not reported	33
Mean Annual Per Capita Income: $417.18	
Range of Means of Annual Per Capita Income for Centers: $184.81 - 716.90	
21. Size of Family:	
2 persons	5
3 persons	14
4 persons	18
5 persons	16
6 persons	14
7 persons	10
8 persons	7
9 or more persons	15
Not reported	1
Mean Size of Family (including extended families): 5.73	
Range of Mean Sizes of Families for Centers: 4.05 - 7.29	
22. Percent of families with extended families	20
23. Mean Size of Nuclear family: 5.17	
Range of Mean Sizes of Nuclear Family for Centers: 3.32 - 6.78	

TABLE B-2 (Continued)

	Percent
24. Number of Families by Total number of children:	
1 child	20
2 children	20
3 children	16
4 children	14
5 children	10
6 children	7
7 children	5
8 children	3
9 children	2
10 children	1
11 children	1
12 or more	1
Mean Number of children per family: 3.60	
Range of Mean Numbers of children per family for Centers: 2.05 - 5.00	
25. Families with siblings older than focal children living at home:	
Yes	68
No	32
Range of families with older siblings living at home: 29 - 90	
26. Number of older siblings by age distribution:	
3 - 4 years	20
5 - 6 years	22
7 -12 years	42
13 -16 years	11
Over 16 years	6
27. Other members living in home (by number of families for each category):	
Grandfather	7
Grandmother	13
Other male relative	12
Other female relative	13
Other adult male	3
Other adult female	2

TABLE B-2 (Continued)

	Percent
28. Families by number of other members living in the home under 21 years old:	
None	91
1 member	3
2 members	2
3 or more members	4
29. Families by number of other members living in the home between 21 and 34 years old:	
None	97.5
1 member	2.0
2 members	0.5
3 or more members	0
30. Families by number of other members living in the home between 35 and 49 years old:	
None	91
1 member	7
2 members	2
3 or more members	0
31. Families by number of other members living in the home between 50 and 64 years old:	
None	94.6
1 member	4.0
2 members	1.4
3 or more members	0
32. Families by number of other members living in the home 65 years of age and over:	
None	98.1
1 member	1.4
2 members	0.5
3 or more members	0
33. Family owns or is buying home:	
Yes	19
No	75
Not reported	6
34. Family lives in public housing:	
Yes	39
No	55
Not reported	6

TABLE B-2 (Continued)

	Percent	Range of Percents
35. Number of rooms in home regularly used for sleeping:		
One	14	
Two	41	
Three	27	
Four	9	
Five or more	5	
Not reported	4	
36. Is there running water in the home:		
Yes	83	
No	14	
Not reported	3	
Range of families with no running water in house for Centers	0-70	
37. How did this family hear about PCC program?		
Door-to-door canvassing	59	
Mass media announcement	4	
Referred by other agency	9	
Individual mail-out	4	
Other	23	
Not reported	2	
38. Previous preschool experience of siblings (by number of families)		
Summer Head Start program only	9	0 - 44
Full Year Head Start program only	10	0 - 49
Other preschool program only	4	0 - 19
Summer Head Start and Full Year Head Start program	1	0 - 7
Summer Head Start and other preschool program	1	0 - 8
Full Year Head Start and other preschool program	1	0 - 7
None	29	8 - 73
No siblings in this age range	24	2 - 57
Not reported	21	0 - 89

TABLE B-2 (Continued)

	% of Siblings
39. Families with siblings who have attended elementary school with a Follow-Through program:	
Yes	6
No	49
No siblings in this age range	24
Not reported	21
Range of siblings attending Follow-Through for Centers	0-21
	Percent
40. Previous Experience of teen-age siblings in:	
Neighborhood Youth Corps	2.0
Job Corps	0.5
Upward Bound	0.5
None of these	17.0
No teen-age siblings	59.0
Not reported	21.0
41. Previous involvement of family members in OEO, DOL, other federal work-training programs:	
Yes	9
No	69
Not reported	22
42. Languages spoken regularly in the home	
English only	85
Indian only	3
Spanish only	6
Other only	3
Two or more	3

APPENDIX C

MEDICAL INFORMATION

FORM C-1: HEALTH STATUS REPORT

TABLE C-2: PCC MEDICAL INFORMATION

TABLE C-3: HEIGHT AND WEIGHT FOR ALL FOCAL CHILDREN

TABLE C-4: PRESENCE OF ILLNESSES AND CONDITIONS

TABLE C-5: SEVERITY OF ILLNESSES AND CONDITIONS

TABLE C-6: TREATMENT OF ILLNESSES AND CONDITIONS

FORM C-1

NATIONAL PARENT-CHILD CENTERS STUDY

KIRSCHNER ASSOCIATES, INC., 11716 WEST PICO BLVD., LOS ANGELES, CALIF. 90064

HEALTH STATUS REPORT

Leave Blank
For National
FORM # 03A
CENTER #
FAMILY #
DATE REC'D.

PART ONE: HEALTH HISTORY

This part of the form is to be completed by Nurse or Family Worker on each child under the age of three years before the child is seen by the Physician.

Center Location ______________________ Date Form Completed ____________
Month Day Year

Full Name of Child ______________________ Name of Parent or Guardian ____________

Sex of child: 1.____Male 2.____Female Date of Birth ______________
Month Day Year

Child's weight at birth:

____________lbs. ________ozs.

Ethnic or Racial Group:
1.____Puerto Rican
2.____Mexican-American
3.____Other Caucasian
4.____Black
5.____American Indi
6.____Polynesian
7.____Oriental
8.____Eskimo
9.____Other

Did the mother have any severe illness, special difficulty or injury during the pregnancy? 1.____Yes 2.____No

What immunizations did the child have before entering the PCC?

DPT 1.____None 2.____Partial 3.____Fully Immunized 4.____Status Unknown

POLIOMYELITIS 1.____None 2.____Partial 3.____Fully Immunized 4.____Status Unknown

SMALLPOX 1.____No 2.____Yes 3.____Unknow

MEASLES 1.____No 2.____Yes 3.____Unknow

Before entering the PCC when was the child's last visit to a doctor?

1.____Within the past year
2.____More than one, but less than two years ago
3.____Two or more years ago
4.____Not since delivery
5.____Unknown

List any severe illnesses or injuries this child has had before entering PCC:______________________

____

____

Is this child now being treated by a physician or clinic for any illness or injury? 1.____Yes 2.____No

Describe:______________________

Did this treatment start prior to acceptance of the child by the PCC? 1.____Yes 2.____No

PART TWO: (TO BE COMPLETED BY EXAMINING PHYSICIAN)

A note to the physician: The constraints of computers are reflected in this form. Space for amplification is provided on page four.

e of examination________________________________

of child in months______________________________

surements (this date) Height______________ins. or Length ______________ins.
Weight______________lbs. ________________oz.

sidering his age and general body build, this child is: 1._____Within average range 2._____Underweight 3._____Overweight

EENING TESTS

erculin 1.____Not Done 3._____Yes, Positive
2.____Yes, Negative If positive, was X-ray picture taken? 4._____Yes 5._____No

mia 1.____Not Done 3.____Yes, Unclear
2.____Yes, Normal 4.____Yes, indicates anemia

Hematocrit, in % volume packed cells_______________%

Hemoglobin, in grams / 100 ml.____________________, in %_______________%.

If anemic indicate probable etiology or type:

1.____type not determined
2.____protein deficiency
3.____iron deficiency
4.____specific infection i.e. malaria, septecemia
5.____abnormal cell structure i.e. sickle cells
6.____pernicious or macrocytic
7.____chemical and hemolytic poisons
8.____parasites, i.e. hookworm

or describe other diagnostic procedures used in this examination. Include tests for which specimens were collected:

____

____

e child eating plaster, paint or chalk? 1._____Yes 2._____No

unizations or Boosters given at this examination:

1._____DPT 3._____Polio 5._____Mumps
2.____Smallpox 4._____Measles 6._____Other

3. SURVEY OF PATHOLOGY AND TREATMENT BASED ON THIS EXAMINATION

If condition is not present mark an X in column O. Mark an X in the appropriate column to indicate the presence, severity and treatment of any medical condition you find in examining this child. If a condition is present that is not included on the list specify under "Other".

Explanations of Code:

O. Not Present: Not apparent or suspected in this examination
1. Condition Previously known (prior to PCC)
2. Mild: Unlikely to interfere with future health
3. Moderate: Likely to interfere with future health if untreated
4. Severe: Will certainly interfere with future health if untreated
5. Severity not estimated - further evaluation needed
6. Condition previously or presently being treated
7. Condition to be treated by this physician or facility
8. To be referred to other Physician, Clinic or Hospital
9. Facilities for treatment not available

	PRESENCE AND SEVERITY						TREATMENT		
	Not Present	Previously Known	Mild	Moderate	Severe	Severity Not Estimated	Already Treated	By Examining Physician	Referred
	0	1	2	3	4	5	6	7	8
A. Behavior or learning difficulty or retardation									
B. Neurological disorder, epilepsy, cerebral palsy									
C. Skin disease, impetigo, eczema lesions									
D. Chronic respiratory diseases (including allergies)									
E. Acute infections, including otitis media									
F. Heart murmur, consultation needed									
G. Definite Heart Disease									
H. Umbilical Hernia									
I. Inguinal, Femoral or other Hernia									
J. Tonsil or adenoid disease									
K. Urinary tract disease or anomaly									
L. Phimosis (circumcision recommended)									
M. Orthopedic defect or disability									
N. Evidence of severe punishment, battered child									
O. Evidence of malnutrition or nutritive deficiency									
P. Chronic diarrhea or vomiting									
Q. Endocrine imbalance disorder									
R. Aural Tract or apparent auditory disorder									
S. Visual Defect or disability									
T. Abnormal dental development, dental disease or problems in dentition (appropriate to age)									
U. Other anomalies or defects									
V. Other diseases, disabilities (specify) ____________									

4.

lease indicate, on the scale below, your overall judgment of the present physical health aside from developmental level, of this child. Use as your norm the average of all children you have seen in your practice, regardless of groups or communities. ircle the number that best indicates your overall judgment at this time.

1	2	3	4	5	6	7	8	9
xceedingly ll, impaired r damaged				Normal Health				Exceptionally healthy and strong

lease indicate on the scale below, your overall judgment of this child's developmental status. Use as your norm the verage of all children you have seen in your practice, regardless of groups or communities. Circle the number that best ndicates your overall judgment at this time.

	2	3	4	5	6	7	8	9
xtremely etarded				Normal for age				Exceptionally precocious

dd or amplify significant datum and recommendations not sufficiently covered in this survey.

________________ Date

________________________________ M. D.
Examining Physician

TABLE C-2

PCC MEDICAL INFORMATION FOR 31 OF 36 CENTERS
(In percent based on 1526 focal children)

	Percent*
Weight of Focal Children at Birth	
Under 5 lbs.	5
5 lbs. - 5 lbs. 15 ozs.	11
6 lbs. - 7 lbs. 15 ozs.	55
Over 8 lbs.	23
Not reported	5
Immunization for DPT Prior to PCC Program	
None	22
Partial	25
Fully Immunized	35
Status Unknown	5
Not reported	12
Immunization for Polio Prior to PCC Program	
None	24
Partial	22
Fully Immunized	32
Status Unknown	6
Not reported	16
Smallpox Vaccination Prior to PCC Program	
No	50
Yes	24
Unknown	7
Not reported	19
Measles Vaccine Prior to PCC Program	
No	47
Yes	27
Unknown	6
Not reported	20
Tuberculin Screening Test During PCC	
Not Done	38
Yes, Negative	29
Yes, Positive	1
Not reported	32

---

* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE C-2 (Continued)

	Percent
Previous Care by Physician	
DNA	68
Less 1 Yr.	25
1 to 2 Yrs.	2
2 + Yrs.	0
Not since birth	2
Unknown	0
Test for Anemia During PCC Program	
Not Done	16
Yes, Normal	33
Yes, Unclear	1
Yes, Anemia Indicated	12
Not reported	37
Hemoglobin Test in Grams/100 ml.	
Less than 5.9	0
6.0 - 7.9	1
8.0 - 9.9	5
10.0 -11.9	16
12.0 -13.9	10
14.0 -15.9	1
Over 16.0	0
Not reported	67
Hematocrit Test in %	
Less than 19.9	0
20.0 - 24.9	0
25.0 - 29.9	2
30.0 - 34.9	10
35.0 - 39.9	14
40.0 - 44.9	2
Over 45.0	0
Not reported	71
Number of Medical Conditions Present Per Child	
None	53
One	20
Two	5
Three	2
Four	1
Over Four	0
Not reported	19

TABLE C-3

HEIGHT AND WEIGHT FOR ALL FOCAL CHILDREN

	HEIGHT				WEIGHT			
	BOYS		GIRLS		BOYS		GIRLS	
	N	MEAN IN INCHES	N	MEAN IN INCHES	N	MEAN IN POUNDS	N	MEAN IN POUNDS
1 MONTHS	7	22	8	21	7	9	11	9
2 MONTHS	11	23	6	23	13	12	5	10
3 MONTHS	9	23	11	27	9	13	11	11
4 MONTHS	17	25	13	25	19	15	14	15
5 MONTHS	13	26	10	25	15	16	13	15
6 MONTHS	8	26	11	27	11	17	11	17
7 MONTHS	6	27	9	27	11	17	11	18
8 MONTHS	13	27	9	26	12	19	11	17
9 MONTHS	11	27	9	28	13	21	11	19
10 MONTHS	14	29	5	29	14	21	7	20
11 MONTHS	12	29	14	29	15	22	17	21
12 MONTHS	16	28	11	29	18	23	14	22
13 MONTHS	8	32	14	30	10	26	15	22
14 MONTHS	8	31	15	29	9	24	18	22
15 MONTHS	6	32	10	30	8	25	10	23
16 MONTHS	15	30	14	30	15	24	16	23
17 MONTHS	12	32	9	31	12	26	12	23
18 MONTHS	12	31	11	33	14	26	13	26
19 MONTHS	21	32	11	33	22	26	11	23
20 MONTHS	15	33	11	32	20	26	14	26
21 MONTHS	19	33	8	32	22	27	10	26
22 MONTHS	18	32	10	33	18	27	11	25
23 MONTHS	18	32	16	32	19	26	17	25
24 MONTHS	16	34	21	33	22	28	23	26
25 MONTHS	11	34	10	34	13	27	11	26
26 MONTHS	16	34	13	34	16	29	13	28
27 MONTHS	6	35	9	34	6	31	10	29
28 MONTHS	10	35	8	35	12	28	10	30
29 MONTHS	7	35	3	31	7	30	4	29
30 MONTHS	17	34	15	35	18	31	16	23
31 MONTHS	8	34	8	35	8	30	9	28
32 MONTHS	10	35	8	35	12	28	10	28
33 MONTHS	12	36	15	35	13	31	15	28
34 MONTHS	7	36	4	33	9	32	8	26
35 MONTHS	3	37	9	35	3	29	9	30
36 MONTHS	14	37	12	37	14	34	12	32

TABLE C-4

PRESENCE OF ILLNESSES AND CONDITIONS

	Percent of Children Examined		Percent of Cases Identified*	
	DNA	Total Cases	Previously Known	Found in PCC Exam
Behavior or learning difficulty or retardation	17	2	20	79
Neurological disorder, epilepsy, cerebral palsy	16	1	57	42
Skin disease, impetigo, eczema lesions	16	7	46	53
Chronic respiratory diseases (including allergies)	18	4	60	39
Acute infections, including otitis media	16	3	22	77
Heart murmur, consultation needed	16	1	19	80
Definite Heart Disease	16	0	37	62
Umbilical Hernia	16	3	37	62
Inguinal, Femoral or other Hernia	16	0	40	60
Tonsil or Adenoid	16	2	31	68
Urinary tract disease	16	0	57	42
Phimosis (circumcision recommended)	17	1	17	82
Orthopedic disability or defect	16	2	42	57
Evidence of severe punishment, battered child	16	0	0	0
Evidence of malnutrition or nutritive deficiency	16	1	26	73
Chronic diarrhea or vomiting	16	0	76	23
Endocrine imbalance disorder	16	0	50	50
Aural Tract or apparent auditory disorder	16	0	37	62
Visual Defect or disability	16	0	28	71
Abnormal dental development, dental disease or problems in dentition (approp. to age)	16	0	50	50
Other anomalies or defects	16	0	26	73
Other diseases, disabilities	16	3	32	67

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE C-5

SEVERITY OF ILLNESSES AND CONDITIONS

	Percent of Cases Identified*				Not
	DNA	Mild	Moderate	Severe	Established
Behavior or learning difficulty or retardation	5	23	8	20	41
Neurological disorder, epilepsy, cerebral palsy	21	15	15	21	26
Skin disease, impetigo, eczema lesions	13	64	17	1	2
Chronic respiratory diseases (including allergies)	25	40	17	1	14
Acute infections, including otitis media	22	42	28	6	0
Heart murmur, consultation needed	4	52	4	4	33
Definite Heart Disease	0	12	37	25	25
Umbilical Hernia	17	71	8	0	1
Inguinal, Femoral or other Hernia	20	20	20	20	20
Tonsil or Adenoid disease	23	42	21	13	0
Urinary tract disease	21	42	28	7	0
Phimosis (circumcision recommended)	21	50	25	3	0
Orthopedic disability or defect	11	48	28	8	2
Evidence of severe punishment, battered child	0	0	0	0	0
Evidence of malnutrition or nutritive deficiency	23	42	30	3	0
Chronic diarrhea or vomiting	61	15	15	7	0
Endocrine imbalance disorder	50	0	0	0	50
Aural Tract or apparent auditory disorder	50	37	12	0	0
Visual Defect or disability	14	28	28	28	0
Abnormal dental development, dental disease or problems in dentition (approp. to age)	37	12	25	12	12
Other anomalies or defects	13	40	26	20	0
Other diseases, disabilities	11	28	26	17	15

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

TABLE C-6

TREATMENT OF ILLNESSES AND CONDITIONS

	Percent of Cases Identified*				
	DNA	Prev. Treat.	Present Treat.	Refer	Treatment Not Available
Behavior or learning difficulty or retardation	67	6	17	5	2
Neurological disorder, epilepsy, cerebral palsy	36	26	26	10	0
Skin disease, impetigo, eczema lesions	56	12	23	4	4
Chronic respiratory diseases (including allergies)	67	5	24	0	2
Acute infections, including otitis media	42	6	45	5	0
Heart murmur, consultation needed	71	9	0	9	9
Definite Heart Disease	62	12	25	0	0
Umbilical Hernia	69	8	12	5	2
Inguinal, Femoral or other Hernia	60	20	20	0	0
Tonsil or Adenoid disease	65	10	18	2	1
Urinary tract disease	50	28	14	7	0
Phimosis (circumcision recommended)	82	3	7	7	0
Orthopedic disability or defect	48	11	25	14	0
Evidence of severe punishment, battered child	0	0	0	0	0
Evidence of malnutrition or nutritive deficiency	65	3	30	0	0
Chronic diarrhea or vomiting	100	0	0	0	0
Endocrine imbalance disorder	100	0	0	0	0
Aural Tract or apparent auditory disorder	75	0	12	0	12
Visual Defect or disability	57	14	0	14	14
Abnormal dental development, dental disease or problems in dentition (approp. to age)	100	0	0	0	0
Other anomalies or defects	60	13	6	6	13
Other diseases, disabilities	34	3	51	7	1

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* In some instances, percentage figures total less than or more than 100 percent due to rounding.

APPENDIX D

PARENT-CHILD CENTER POLICY PRIORITIES

FORM D-1: CENTER POLICY PRIORITIES

TABLE D-2: RANK ORDER OF MAIN CONCERN OF CENTERS

TABLE D-3: RANK ORDER OF MAJOR PROGRAM GOALS OF CENTERS

FORM D-1

CENTER POLICY PRIORITIES

There are many worthwhile objectives to be sought by a Parent-Child Center. Since centers will differ in their focus and priorities, and these decisions will affect their structure and program. This questionnaire will help us understand the policy priorities of your center.

From each group of three statements select the most important and the least important of those three even if it's very close. Answer every set.

1. The main concern of this center is with:

Most Impt.	Least Impt.		
________	________	(1)A.	Infants and toddlers
________	________	B.	Mothers and fathers
________	________	C.	Total family
________	________	(2)D.	Mothers and fathers
________	________	E.	Total family
________	________	F.	Neighborhood change
________	________	(3)G.	Infants and toddlers
________	________	H.	Mothers and fathers
________	________	I.	Training its own indigenous staff members
________	________	(4)J.	Mothers and fathers
________	________	K.	Total family
________	________	L.	Indigenous staff
________	________	(5)M.	Infants and toddlers
________	________	N.	Mothers and fathers
________	________	O.	Neighborhood change
________	________	(6)P.	Total family
________	________	R.	Neighborhood change
________	________	S.	Indigenous staff

FORM D-1 (Continued)

2. The main thing the Center should accomplish is:

Most Impt.	Least Impt.	
______	______	(1) A. Assuring healthy babies
______	______	B. Making a better neighborhood
______	______	C. Helping parents become independent
______	______	(2) D. Making a better neighborhood
______	______	E. Helping parents become independent
______	______	F. Helping infants develop in learning and social skills
______	______	(3) G. Assuring healthy babies
______	______	H. Making a better neighborhood
______	______	I. Training people for jobs
______	______	(4) J. Training people for jobs
______	______	K. Training better parents
______	______	L. Helping infants develop in learning and social skills
______	______	(5) M. Making a better neighborhood
______	______	N. Helping parents become independent
______	______	O. Training people for jobs
______	______	(6) P. Assuring healthy babies
______	______	Q. Making a better neighborhood
______	______	R. Training better parents
______	______	(7) S. Making a better neighborhood
______	______	T. Helping parents become independent
______	______	U. Training better parents
______	______	(8) V. Helping parents become independent
______	______	W. Training people for jobs
______	______	X. Helping infants develop in learning and social skills
______	______	(9) Y. Helping parents become independent
______	______	Z. Training people for jobs
______	______	AA. Training better parents
______	______	(10) BB. Assuring healthy babies
______	______	CC. Making a better neighborhood
______	______	DD. Helping infants develop in learning and social skills

TABLE D-2

RANK ORDER OF MAIN CONCERN OF CENTERS

Main Concern of Center	Mean	Number of Centers Selecting Each Rank 1	2*	3*	4*	5*	Totals
Infants and Toddlers	1.29	17	12	1	0	1	31
Total Family	1.70	11	7	6	5	2	31
Mothers and Fathers	2.08	0	9	15	6	1	31
Training of Indigenous Staff	2.23	3	5	7	10	6	31
Neighborhood Change	2.76	0	0	4	9	18	31

TABLE D-3

RANK ORDER OF MAJOR PROGRAM GOALS OF CENTERS

Major Program Goals	Mean	Number of Centers Selecting Each Rank 1*	2*	3*	4*	5*	6*	Totals
Helping Infants Develop in Learning and Social Skills	1.27	17	9	4	0	1	0	31
Assuring Healthy Babies	1.42	9	13	6	2	1	0	31
Training Better Parents	1.59	7	9	7	5	1	2	31
Helping Parents Become More Independent	1.74	3	4	14	7	3	0	31
Training People for Jobs	2.65	1	1	0	7	12	10	31
Making a Better Neighborhood	2.68	0	0	1	9	12	9	31

*Because of Tied Ranks, columns do not equal the total number of centers responding.

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APPENDIX E

THE NATIONAL TEST SAMPLE

The Bayley Scales of Infant Development were administered to 109 children at six Parent-Child Centers upon or shortly after their acceptance for service by the PCC. Seventy-nine of these children were reexamined ten months later using the same scales.

This sample was not designed as either a representative sample of all PCC children nor will these findings be used for a formal outcome study. Rather the sample is both illustrative of the characteristics of the children being served and could serve as to provide feasibility data for a possible outcome study which might be undertaken after the programs of the Centers become stabilized.

THE INSTRUMENTS

The Bayley Scales are a newly developed tool in the description of an infant's development. Based upon decades of research by Dr. Nancy Bayley of the University of California, the scales yield two scores, measurements of mental and of motor development.

The "Mental Development Index" (MDI) is based on test items assessing the child's sensory-perceptual acuities and responses; his awareness of "object constancy" and ability to remember and learn, vocalizations and attempts at verbal communication; and his early efforts to generalize and classify.

The "Psychomotor Development Index" (PDI) is derived from an assessment of the child's degree of body control and his abilities in the coordination of both large and small muscles in performing motor tasks.

The Scales were individually administered to each child by our psychometrist,[1] in the presence of the mother. (Systematic observations of mother-child interaction were also recorded.) On the average, an hour and a quarter was spent with each child and his mother in a room provided by the centers.

The Bayley Scales were standardized on a stratified sample of 1262 children controlled for sex, race, age, urban-rural residence, and the education of the head of the household. The scores reported here are a comparison with this initial standardization group. The usual psychometric convention in score designation is retained; a score of 100 indicates that the child's performance was at the mean of his age group.

THE PRETEST

Pretest Sample

The 109 infants we examined were newly enrolled in six PCC programs at six centers. Three of these are rural centers and three are urban.

One each is located in the Northeast, the Middle Atlantic, the South, the Midwest, the Southwest, and the Northwest.

Table E-1 describes the age, sex, and ethnicity of our sample. As can be seen, the ethnic distribution was reasonably even. Fifty-five percent of the youngsters were boys and forty-five percent were girls.

The boys were, on the average, two and one half months older than the girls as indicated in Table E-2; the respective mean ages were fourteen months and eleven and one half months. This difference is mainly produced by the much younger ages of the girls at Centers 1 and 29, one of which is urban and the other of which is rural.

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[1] Three other Centers are using the Bayley Scales for their own records. Their findings are excluded here in order to avoid problems of interpreting differences between examiners.

TABLE E-1

Number of Children Tested by Age, Sex, and Ethnicity

Age	Hispano		Anglo		Negro		
	Boys	Girls	Boys	Girls	Boys	Girls	Total
0 - 4 months	3	1	2	4	4	5	19
5 - 8 months	3	2	1	5	4	3	18
9 -12 months	1	2	2	2	4	4	15
13 -16 months	3	7	4	3	6	3	26
17 -20 months	5	1	4	2	4		16
21 -24 months	2	1	4		3	4	14
25 -28 months					1		1
Totals	17	14	17	16	26	19	109

TABLE E-2

Mean Age of Children at Testing

Center	Number of Boys	Mean Age	Number of Girls	Mean Age
Center 29	10	14 mos., 27 days	8	7 mos., 21 days
Center 5	10	13 mos., 3 days	9	14 mos., 1 day
Center 1	9	15 mos., 21 days	10	9 mos., 21 days
Center 25	11	15 mos., 21 days	7	13 mos., 15 days
Center 30	10	12 mos., 24 days	7	13 mos., 27 days
Center 16	10	12 mos., 21 days	8	10 mos., 27 days
Totals	60	14 mos., 6 days	49	11 mos., 18 days

Pretest Results

An interesting sex difference occurs in the distribution of test scores, as is shown in Table E-3. In this sample it is clear that on both indices, larger proportions of boys than girls fall below the normal range of scores, and conversely, that a larger percentage of girls fall into the normal range.

TABLE E-3

Pretest Scores According to Sex of Child

	N	Bayley Mental Development Index					
		89 or below		Normal Range 90-109		Above 110	
		N	%	N	%	N	%
Boys	60	52	87	5	8	3	5
Girls	49	31	63	16	33	2	4
		Bayley Psychomotor Index					
		89 or below		Normal Range 90-109		Above 110	
		N	%	N	%	N	%
Boys	60	28	47	27	45	5	8
Girls	49	14	29	28	57	7	14

While we do not have any explanation of this difference, and recognize that it may be an artifact of the sample, it is reminiscent of the findings in the Berkeley Growth Study, whose subjects have been followed from infancy for the last 38 years. These data suggest that females may be more refractory to psychological damage than males, and may recover from trauma more completely. It will be interesting to see if the intervention of the centers reduces this gap between the score distributions.

TABLE E-4

Number of Pretest Sample Subjects According to Income and Ethnicity

	Per Capita Income (Annual)			
	$700+	$300-$700	Under $300	N
Anglo	13	10	10	33
Hispano	4	16	11	31
Negro	17	13	15	45
N =	34	39	36	109

When income levels are tabulated by ethnicity, it appears that the sample is somewhat skewed in one area; only 4% of the Hispano children live in families with per capita incomes above $700. However the sample as a whole is fairly evenly spread over this income range.

Analysis of Results

Total Sample

The overall findings are summarized in Table E-5 below.

TABLE E-5

Overall Findings of BSID Pretest

	Bayley Mental Development Index	Bayley Psychomotor Development Index
Mean	77.6	90.4
Standard Deviation	7.4	8.7
Interquartile Range	66-90	78-105
Total Range	23-136	35-124

The difference between motor and psycho-social scores has been noted in previous studies of low-income infants. Because these earlier findings have usually been attributed to ethnicity, we were interested in seeing whether such a relationship existed in these data.

As Table E-6 shows, we found no meaningful ethnic differences either in score levels or in the psychosocial-motor index differences.

TABLE E-6

Mean Scores on Pretest by Ethnicity of Subject

	N	MDI	PDI
Anglo	33	78.3	89.5
Hispano	31	74.8	91.1
Negro	45	79.0	90.5
Total N	109		

Earlier studies have reported significant differences between urban and rural children, which we did not find.

TABLE E-7

Mean Scores on Pretest by Rural or Urban Residence of Subject

	N	MDI	PDI
Rural	54	75.2	89.6
Urban	54	79.9	91.6
Total N	109		

There were no significant differences in scores when they were related to the per capita family income. In Table E-8, the test scores and income categories represent quartiles; the highest and lowest categories are the first and fourth quartiles of this sample; the middle category contains the second and third quartiles.

TABLE E-8

Per Capita Income and Pretest Scores

	MDI Scores					PDI Scores			
Per Capita Income	N	91+	66-90	65-	Means	106+	78-105	77-	Means
Over $700	34	96.6	78.6	51.6	71.4	112.4	94.5	65.5	90.1
$300-$700	39	100.8	79.5	55.0	79.4	110.6	92.7	69.0	92.0
Under $300	36	98.8	78.3	57.0	79.0	114.2	92.8	68.7	89.8
N	109	26	53	30		18	67	24	
Means		98.9	78.9	53.9		112.4	93.2	66.7	

While none of these differences is significant, it is noteworthy that the lowest mean MDI score is held by the children whose families have the largest per capita income.

We further explored whether the interaction of ethnicity and income might produce the significant differences reported by some investigators. Some differences do appear when the data are cross-tabulated in this way. On the Mental Development Index, Anglo children from the highest income group score lowest among the ethnic groups, and lower than the lower-income Anglo children. One can only explain this, it seems to us, as an artifact of the sample. The high PDI score of middle-income Hispano youngsters is based on an N of four cases, and is probably also a function of the sample. However, the lower MDI score of the poorest Hispano children seems as though it may be a reliable finding.

TABLE E-9

Income, Ethnicity, and Pretest Scores

		Annual Per Capita Income							
		Over $700		$300-$700		Under $300		Means	
Ethnicity	N	MDI	PDI	MDI	PDI	MDI	PDI	MDI	PDI
Anglo	33	72.8	83.8	81.9	94.5	82.9	91.9	78.6	84.3
Hispano	31	78.2	104.5	76.0	90.4	74.0	86.0	74.8	91.1
Negro	45	75.4	91.6	81.8	92.2	81.5	90.9	79.3	91.6
N	109	34	34	39	39	36	36		
Means		74.7	90.0	79.5	92.1	79.6	89.7		

Table E-10 indicates that there are no significant differences between performances of rural and urban children when their scores are grouped by ethnicity. This table is incomplete because we do not have any children of Hispanic family origins in any of our urban samples. Indeed there are very few such children reported from the urban centers thus far, although several are in cities with sizable Spanish-American, Puerto Rican, and Mexican-American populations.

TABLE E-10

Ethnicity, Residence, and Pretest Scores

		Rural		Urban		Means	
Ethnicity	N	MDI	PDI	MDI	PDI	MDI	PDI
Anglo	33	81.2	93.8	82.3	91.3	78.6	84.3
Hispano	31	74.8	91.1	0	0	74.8	91.8
Negro	45	75.0	73.0	79.2	91.1	79.3	91.6
N	109	54	54	55	55		
Means		75.2	89.6	79.9	91.1		

We examined the data to see if test scores were related to either the age of the mother or the size of the family, and found no relationship of test scores to either of these variables.

We further wondered whether the kinds of resources already widely available in a community might be related to test scores. Infant mortality rates were selected as an indicator of such resources, since it has been shown that widely available prenatal and infant care services and nutritional services do correlate with lowered rates of infant mortality.

Average infant mortality rates for the years 1961-1965 were obtained for each county in which the six centers in the sample are located. Neither the overall rate nor the rate for similar sub-populations seems to be related to these scores. A portion of these data is reproduced for the reader's inspection in Table E-11 below.

TABLE E-11

Relationship of Pretest Scores According to Local County Infant Mortality Rates

Center	Infant Mortality, Rate per 1000 Live Births	MDI	PDI
25	29.0	75	87
30	29.0	75	93
5	28.1	75	89
1	27.3	80	93
16	25.7	84	93
29	25.1	76	87

Age Differences

Tables E-12 and E-13 provide the mean scores and score distributions for children who were tested at various ages. These data provide a gross cross-sectional look at what may happen to children raised in impoverished families. Several facts in each table are noteworthy.

On the Mental Development Index we see what appears to be a steady drop in ability with age. Only 32% of the children under four months of age fall below the normal range, while over 93% of youngsters over 17 months of age fall below the normal range. While this difference is less pronounced on the motor scales it is, nonetheless, significant. Where less than a fourth of children under 17 months of age score below the normal range, three-fourths of those over 17 months of age fall in the lowest category.

TABLE E-12

MDI Pretest Scores According to Age Category of Subject

		Bayley Mental Development Index						
		89 or below		Normal Range 90 - 109		Above 110		
Age	N	N	%	N	%	N	%	Means
0-4 months	19	6	32	11	58	2	10	95
5-8 months	18	14	78	3	17	1	5	81
9-12 months	15	13	87	2	13	0	0	75
13-16 months	26	21	81	5	19	0	0	73
17-20 months	16	15	94	0	0	1	6	68
21-24 months	14	13	93	0	0	1	7	73
25-28 months	1	1		0	0	0	0	78
Totals	109	83		21		5		78

TABLE E-13

PDI Pretest Scores According to Age Category of Subject

Age	N	Bayley Psychomotor Development Index						
		89 or below		Normal Range 90 - 109		Above 110		Means
		N	%	N	%	N	%	
0-4 months	19	5	26	12	63	2	11	97
5-8 months	18	5	28	9	50	4	22	94
9-12 months	15	3	20	11	73	1	6	92
13-16 months	26	6	23	16	62	4	15	95
17-20 months	16	12	75	4	25	0	0	79
21-24 months	14	10	72	2	14	2	14	81
25-28 months	1	1	*	0	0	0	0	77
Totals	109	42		54		13		90

* Percentage cannot be computed on only one case.

Mental-Motor Differences

As Table E-5 indicates, both boys and girls at all centers score higher on the motor index than on the mental index. (The one exception to the rule is provided by Center 16, where girls scored one point higher on the MDI than on the PDI. The difference existing at Center 16 is due to the two children who achieved scores of 120 and 139 on the mental index.)

There is a 14-point difference between the mean mental and motor scores for all boys. The range of the differences between the means is from 5 to 22 points. There is also a 14-point difference between the mean mental and motor scores of all girls. Excluding Center 16, range of the differences between the means is from 6 to 34 points.

When scores are grouped into those below the norm, within the normal range, and above the norm, the differences between mental and motor performances become more apparent.

TABLE E-14

Bayley Mental and Motor Indices

		Below 89		Normal Range 90 - 109		Above 110	
	N	N	%	N	%	N	%
MDI	109	83	77	21	19	5	4
PDI	109	42	39	55	50	12	11

Table E-15 displays the means for boys and girls, for both groups, and the score ranges for each center. Tables E-16, E-17, and E-18 display the score distributions by age, sex, and center.

There are relatively few differences in the test scores of the children at the six different Parent-Child Centers. While scores are generally low, they are lower for mental than for motor performance; they are lower for older than for younger children. That the scores are lower for boys than they are for girls seems primarily related to the fact that the boys in the sample are older than the girls.

TABLE E-15

MDI and PDI Range and Means for Boys, Girls, and all Children for Total Sample and by Center

Center	MDI Range	MDI Means		
		Boys	Girls	Both
29	34-101	72	81	76
5	50-111	76	75	75
1	42-110	75	34	80
25	55-99	73	79	75
30	28-97	79	67	75
16	50-136	77	94	84
Totals	28-136	74	80	78
		(4532)= (75.53)	(3926)= (80.12)	(84.58)= (77.59)

Center	PDI Range	PDI Means		
		Boys	Girls	Both
29	35-118	84	91	87
5	67-124	88	91	89
1	48-124	84	101	93
25	66-110	84	90	87
30	76-110	92	96	93
16	60-117	94	93	93
Totals	35-124	83	94	90

TABLE E-16

Distributions of Pretest Scores by Age or Subject

Age in Months	Bayley Mental Development Index															
	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
0-4 months						1	5	9	2	1	1					
5-8 months		1	1			8	4	2	1			1				
9-12 months			1	1	2	5	4	1	1							
13-16 months	1			3	7	4	6	5								
17-20 months			2	5	2	3	3			1						
21-24 months				3	4	2	4			1						
25-28 months						1										

Age in Months	Bayley Psychomotor Development Index															
	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
0-4 months							5	7	5	1	1					
5-8 months				1	1	2	1	5	4	4						
9-12 months		1				1	1	8	3		1					
13-16 months					2	3	1	8	8	4						
17-20 months					5	6	1	4								
21-24 months			1		2	4	3	1	1	2						
25-28 months						1										

TABLE E-17

Distribution of MDI Pretest Scores by Center and Sex of Subject

	Bayley Mental Development Index															
BOYS (N=60)	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
Center 29			1	1	3	2	1	2								
Center 5				2	2	3	1	1		1						
Center 1			2			2	4			1						
Center 25				2	1	6	2									
Center 30				1		3	4	2								
Center 16				1	2	3	3			1						
Totals			3	7	8	19	15	5		3						

	Bayley Psychomotor Development Index															
GIRLS (N=49)	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
Center 29		1			1		2	3	1							
Center 5				2	2	1	2	1	1							
Center 1			1		1		3	4	1							
Center 25					2	3	1	1								
Center 30	1			2		1	2	1								
Center 16				1	1		1	2	1		1	1				
Totals	1	1	1	5	7	5	11	12	4		1	1				

TABLE E-18

Distribution of PDI Pretest Scores by Center and Sex of Subject

BOYS (N=60)	Bayley Mental Development Index															
	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
Center 29		1			1	1	3	3		1						
Center 5					2	3	3	3	1		1					
Center 1			1		1	1	1	4		1						
Center 25					3	2	1	3	1	1						
Center 30						2	2	3	3							
Center 16						3		2	4	1						
Totals		1	1		7	12	7	18	9	4	1					

GIRLS (N=49)	Bayley Psychomotor Development Index															
	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140-149	150-159	160-169	170-179
Center 29				1			2	3	1	1						
Center 5					1	1	1	2	4							
Center 1					1	1	1	1	1	4	1					
Center 25						2		3	2							
Center 30						1		3	2	1						
Center 16					1		1	3	3							
Totals				1	3	5	5	15	13	6	1					

SUMMARY OF PRETEST FINDINGS

Although these children live in different parts of the country, are rural and urban in their residence, come from families of different ethnic groups and size, and have mothers ranging in age from 16 to 40, none of these differences are reflected in their developmental scores.

What is suggested is that as these low-income children grow older their developmental status declines. Certainly it seems clear that most of those children past the age of four months are functioning less well than the standardization group, from whom they differ only in economic level and, consequently, in the medical, nutritional, and stimulation levels which accompany large income differences. Indeed, since the standardization group includes poor children, the actual differences are somewhat understated by these scores.

APPENDIX F

FRAMEWORK FOR COST-OUTCOME ANALYSIS AND PROCEDURES

COST-OUTCOME ANALYSIS

INTERIM PROCEDURES FOR COST ANALYSIS

FORM F-1: PCC DIRECTORS QUARTERLY PROGRAM ACCOUNTS REPORT

FORM F-2: QUARTERLY INCOME REPORT

FORM F-3: STAFF TIME ACTIVITIES SUMMARY

APPENDIX F

FRAMEWORK AND PROCEDURES FOR COST-OUTCOME ANALYSIS

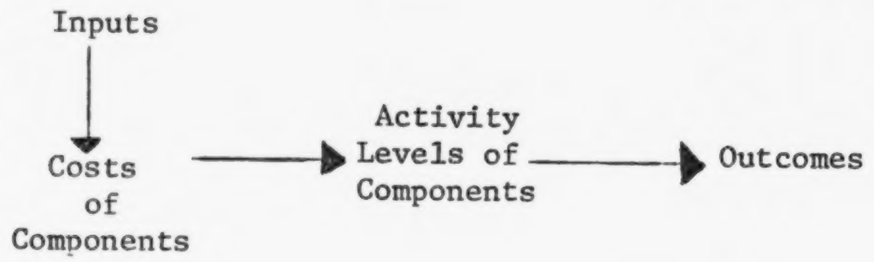
COST-OUTCOME ANALYSIS

For purposes of analysis, PCC's may be viewed as having the following elements: (1) program components or functions, each of which has an activity level; (2) program costs; (3) program outcomes. The program functions include such activities as child development, health care, parenthood training, and social services provided by center personnel. Associated with each component of the center program is a level of activity of the component. For example, the activity level of the health care component might be measured by the number of medical examinations of children and parents conducted during a specified time period. Similarly, the level of activity of the parenthood training component might be measured by the number of hours that parents spend in such activities in the center during a specified period of time.

Each component or function of the center program thus has an activity level associated with it. In addition, each function has an associated level of costs. The costs would include labor, material, and supply costs of the designated function plus overhead costs imputable to the component.

A PCC will, from this point of view, also generate a series of outcomes, including the possibility of a zero level of outcome. Outcomes would include, for example, the possible improvement in the physical health of families enrolled in the program, an improvement in language skills of children beyond that which would occur in the absence of the PCC, and improvements in other aspects of child development which would not have occurred without the center program. The development of such measures of program outcome is not a matter of concern here, although, needless to say, such development and measurement will prove difficult and time consuming.

These concepts may be diagrammed in the following manner:



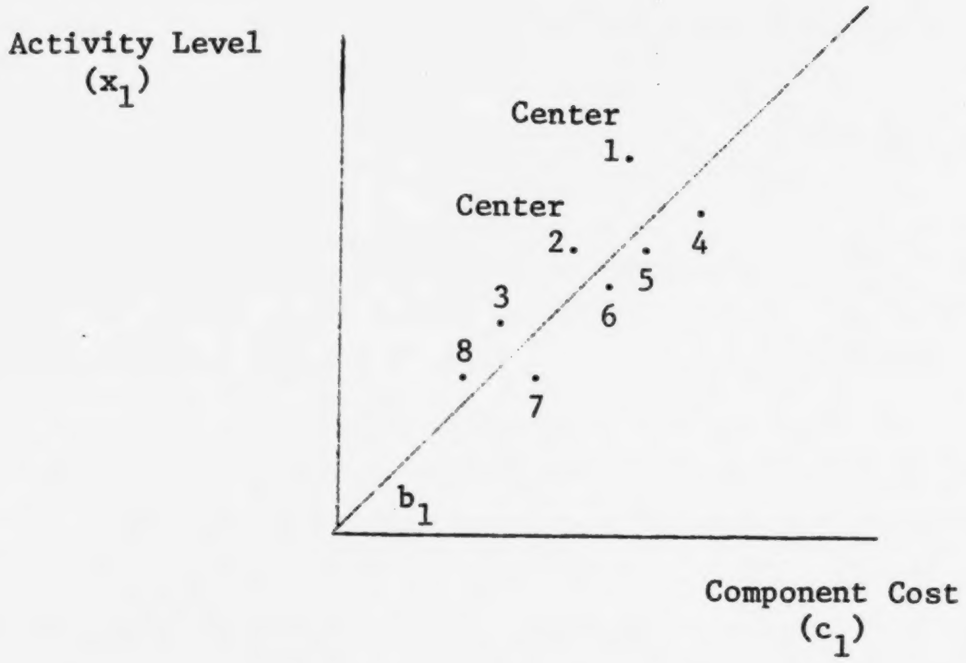
The input of resources into the PCC functions results in costs being incurred but also in the functions being carried on at certain activity levels. The result of the activity levels of the various functions is a series of outcomes, which represent benefits of the center program.

The concepts may be specified, in addition, as follows: Let the activity levels of the different functions be designated by $x_1, x_2, x_3, \ldots, x_n$; that is, x_1 is the activity level of function 1, etc. Let the cost levels of the different functions be $c_1, c_2, \ldots, c_n$; that is, c_1 is the total cost per unit of time associated with function 1. Let the outcomes of the center program be $y_1, y_2, \ldots, y_n$; for example, y_1 is the measure of improvement of health of children resulting from the center operation.

It may be noted,

(1) $x_1 = b_1 c_1$.

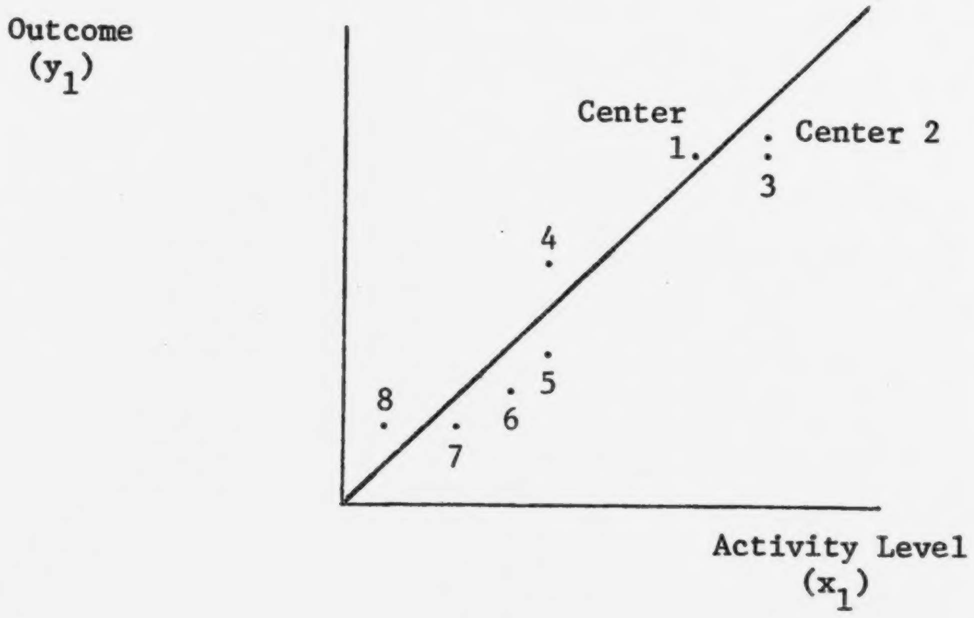
That is, the incurring of costs at the level c_1 in function 1 results in an activity level of x_1 for that function. The magnitude of b_1--the coefficient for translation of cost into activity level--might be determined by regression analysis, if there are available for different centers the cost and activity levels of the particular components as shown below.



The second step in the analysis would be to relate the outcomes to the activity levels. For example, if y_1 is a measure of health improvement and x_1 the activity level of health care programs, then, perhaps,

(2) $y_1 = a_o = a_1, x_1$.

Once again, if data are available for various centers on these magnitudes, the coefficients of the equation might be determined by regression analysis:



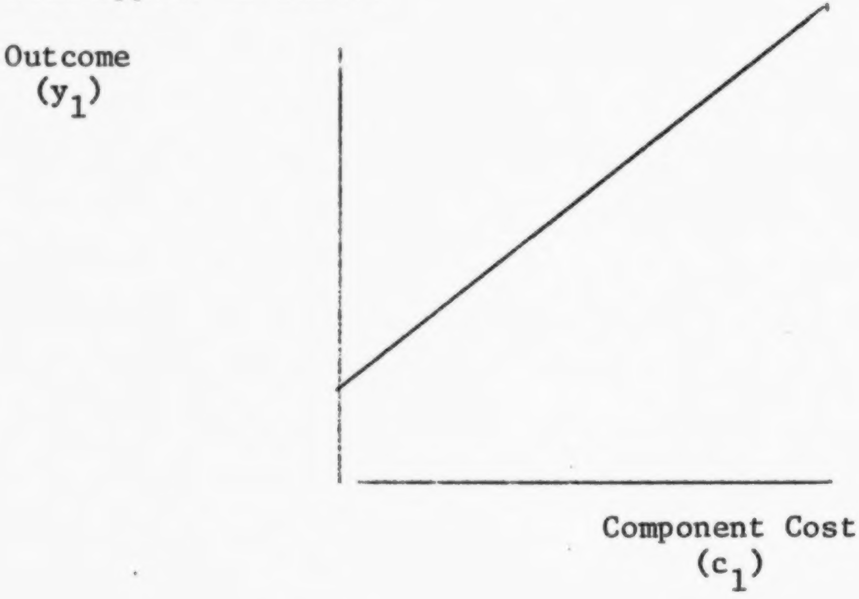
If this proves feasible, then equations (1) and (2) could be combined into

(3) $y_1 = a_o + (a_1\ b_1)\ c_1.$

Let $\alpha_1 = a_1\ b_1$

$y_1 = a_o + \alpha_1\ c_1$

which would appear as below:



From such a relationship, it would be possible to predict the program outcome in the dimension specified from a designation of the expenditure (cost) to be devoted to the particular component.

It is worth emphasizing that the measures of "benefits" suggested--the "outcomes" mentioned above--would be nonmonetary measures, although it would be necessary to quantify the outcomes. Thus, a benefit-cost ratio would not be determined, but it would be possible, if the above method proves feasible, to specify, for example, "degree of improvement in health per dollar of cost," "degree of increase in productivity per dollar of cost for parent training," or "degree of increase in infant verbal skills per dollar of cost."

INTERIM PROCEDURES FOR COST ANALYSIS

Since comprehensive outcome data are not likely to be available for some time, it is useful to specify analyses that can be made in the interim assuming the availability of adequate cost data.

First, the data collected in the Program Accounts Report and the Staff Activities Summary Report could be used for a simple, descriptive analysis of the PCC program. That is, tabulations showing the number of families, children, and parents being served by each center, tables and graphs showing the costs of each type of program service in each center, and tables that quantify the amount of staff time devoted to each program activity could be prepared and could be coupled with verbal descriptions. Similar tables and graphs could be prepared for the program as a whole, on a national level. These data would be used only for the purpose of description: there would be no analysis of the interrelationships of the variables being measured or of the relationships of these variables with other program variables. Such a procedure would, of course, provide only limited insight into the PCC program; yet, at least this much can and should be done with the data being collected.

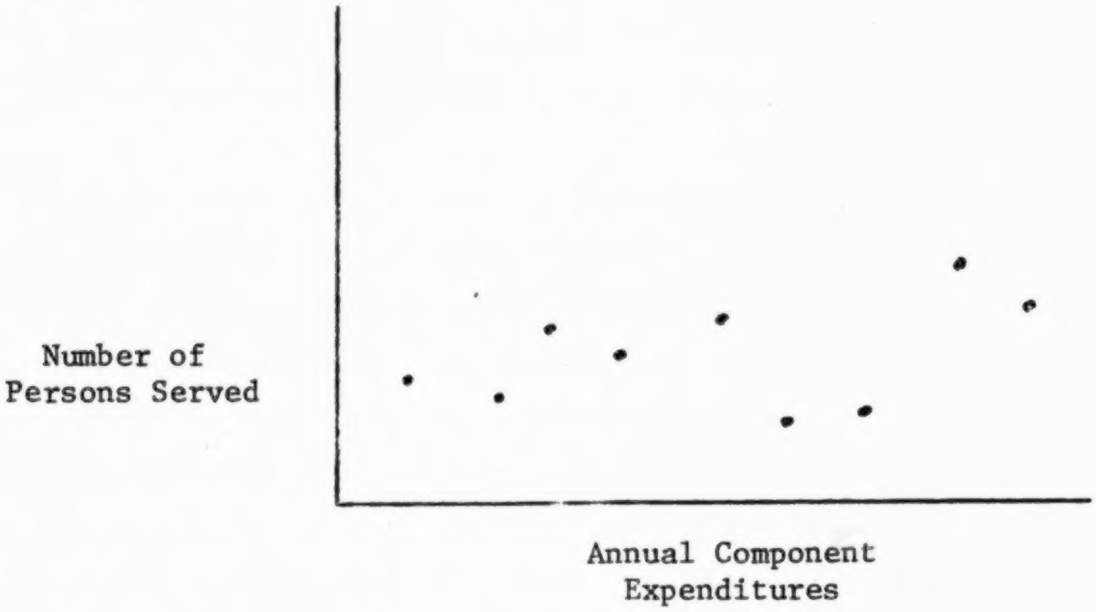
Second, a somewhat more elaborate study could be performed by using the data collected on these two forms for a comparative analysis of PCC's. That is, on the basis of information concerning the cost of each type of service provided and concerning the number of persons served by each program component, PCC's could be compared to one another.

An example of such a comparative analysis is the following: on the basis of data collected from the Program Accounts Report, national PCC expenditures could be determined for each type of program service outlined on the Program Accounts Report and the frequency distribution determined of national PCC expenditures. Next, a frequency distribution of expenditures could be computed for each PCC. Then the degree to which the local PCC expenditure pattern departs from the national pattern of expenditures can be determined, and such a determination may be used to assess the characteristics that are unique to each PCC. One manner in which a determination of the degree of departure of local from national PCC cost patterns could be made is by statistical tests of significance on the local and national PCC expenditure frequency distributions. Whether this particular form of analysis is utilized is irrelevant; the point is that it is possible to use some form of comparative analysis of the cost and staff activity data.

A third, and still more elaborate, form of analysis would be an "input-outcome" analysis. Program inputs may be identified as the levels of activity in different program components. The program components could be defined as those for which data are being collected on the Program Accounts Report, and the level of activity might be defined as the total annual expenditures on each program service. Thus, "program inputs" could be defined as annual expenditures on each program service in a PCC. So defined, there would be as many program inputs as there are program services identified on the Program Accounts Report.

The main problem in the analysis is to determine the relationship between program inputs, as defined above, and program outcomes. Consequently, if this type of analysis is to be conducted, there must be a clear definition of program outcome. Since sophisticated outcome measures are assumed not to be available, proximate measures of outcome could be utilized.

At a rather naive level, program outcome could be identified as the number of persons served by each program component or as the number of persons contacted (number of persons served multiplied by number of times served) by each program component. Such a measure is, of course, inadequate because "serving" a person or "contacting" a person may not have a positive result; in fact, the result of service could conceivably be negative. However, some analysis at this level might be of interest. If so, it could be conducted as follows: for each PCC, determine the amount of annual expenditures and the yearly number of persons served (or contacted) by each program service of the PCC. For each program service, consider these two measures for each PCC; they could be plotted in a diagram as follows:



That is, letting:

y_{ij} = number of persons contacted per year in the i^{th} PCC in the j^{th} service

x_{ij} = annual expenditures by the j^{th} service in the i^{th} PCC

e_{ij} = random variables with expected value zero, uniform variance, and distributed independently for all i

we have the regression model:

(1) $y_{ij} = a_j + b_j x_{ij} + e_{ij}$

for $j = 1, \ldots\ldots, m$; assuming there are m program components

There are two possibilities:

(1) $b_j = 0$ for the $j^{\underline{th}}$ program component. That is, when the regression is fitted, b_j tests to be not significantly different from zero. In this case, there is no relationship between component input and the defined component outcome.

(2) $b_j \neq 0$ for the $j^{\underline{th}}$ program component. In this case, there is a relationship between the defined program input and the defined program outcome. b_j measures the magnitude of the relationship; in fact, b_j shows the incremental number of persons served (or contacted) by the component for an incremental input of dollar expenditure.

To perform a more serviceable input-outcome analysis, it is, of course, necessary to define outcomes in terms of the intended outcomes of the program, and it is necessary to have measures of those outcomes.

FORM F-1

PCC DIRECTORS QUARTERLY PROGRAM ACCOUNTS REPORT

INTRODUCTION

This fiscal report form is designed to provide accurate information as to how much each major aspect of a PCC program actually costs. This information will enable you and OEO to assess the costs and, later, the benefits to be derived from various kinds of program components, and to plan future programs more accurately.

You will see at once that it requires a different kind of record-keeping than is usually with OEO-CAP grants. For example, supplies are allocated to their specific uses rather than lumped together. A person who does more than one kind of thing in your program will be located in each of the separate categories in which he works, his salary being allocated among them in proportion to the time he spends at each function.

You will find this kind of budgeting really very useful as your program grows and you need to add or re-assign staff and other resources.

This form is not necessarily permanent; as your reports come in, it will be changed to make it more useful -- and usable.

If you have any questions about how to use this form, or any difficulty in understanding it, or suggestions for improving it, please contact the Director, National Parent Child Centers Study, Kirschner Associates, 11716 West Pico Boulevard, Los Angeles, Calif. 90064.

Start this report at the first day of the seventh month after the effective date of your initial grant. For most Centers this will be January 1, 1969.

FORM F-1 (Continued)

QUARTERLY PROGRAM ACCOUNTS REPORT

DEFINITIONS AND MANUAL

PART ONE: VOLUME OF DIRECT SERVICE ACTIVITIES

This report tells us the numbers of contacts, the numbers of people served, and the numbers of referrals made during the past quarter.

It should be prepared along with the MIS Statistical Report, because both use the same raw data, although they use it differently. We are avoiding unnecessary duplication by asking that you attach a copy of the MIS report to this sheet when you return it to us.

DEFINITIONS OF COLUMNS

1. NUMBER OF DIFFERENT PERSONS SERVED

For each account list the number of persons, no matter how often they have been served. The maximum number for any line is the number of people in the group who are being served. For example if all the infants enrolled received program services during the quarter, then the number on line 11, column 1 would equal the center's total enrollment of children under 36 months of age.

Column 2. NUMBER OF CONTACTS

This is the number of times a given service was offered to any enrollee. For example, if a course in sewing was offered to parents, and ten mothers came to fourteen meetings of that class during this reporting period, this would equal 10 mothers x 14 classes = 140 contacts. This number, along with other contacts would be included in the number in line 24, column 2. Similarly, if twenty infants received medical examination and five of them had one additional appointment each for tests, this would equal 25 contacts for line 12, column 2.

Column 3. NUMBER OF REFERRALS

The grand total of this column will equal the total of referrals listed on the MIS statistical summary. This column asks you to divide that number among the main reasons and persons referred. For example, if a family is referred to the Salvation Army for a layette for the expected infant, this referral would count as a program service for a child under 36 months of age (line 11, column 3). A referral to the County Health Department for an examination of a 4 year old would be listed in line 32, column 3.

FORM F-1 (Continued)

If a referral is for the whole family; say for food, list it as a Service to Parents.

Notice that, under Services to Parents we distinguish between "Classes and Instruction" and "Meetings".

"Classes and Instruction" includes classes in child development, individual instruction in infant stimulation, and lectures on consumer law. Classes on cooking or nutrition, however, should be included under Nutrition and Food.

"Meetings" include planning meetings, PAC meetings, general public information sessions, and other meetings concerned with operation of the PCC.

FORM F-1 (Continued)

QUARTERLY PROGRAM ACCOUNTS REPORT

DEFINITIONS AND MANUAL

PART TWO

Eight major account series are defined in this report form:

Series 10	Services to children ages 0-36 months
Series 20	Services to parents of these children
Series 30	Services to children over 3 years of age and other family members
Series 40	Community and Interagency activities
Series 50	Administration and supportive services
Series 60	Transportation and Travel
Series 70	Non-recurring costs
Series 80	Other

Each of these is broken down into major categories of service. Numbers are left in each series to add other types of service not included in these categories. Each category is numbered within each account; i.e. medical care for an infant is listed as number 12 in Account Series 10.

When completed, the form will provide the amount of money spent on each category of activity, the expenditures for the quarter, and with Part One, the number of persons involved in each service, and the number of different people served.

This form is keyed to both the Income Report and Staff Time Activities Summary which are to be completed at the same time.

In the manual which follows, unbracketed numbers refer to Accounts and categories listed on the left edge of the report forms. Bracketed numbers refer to the columns across the form.

Each category of expense is broken down by federal and local shares.

Do not report cents. Report only dollar amounts in each space. Round off to the nearest dollar. If the amount of cents in a figure is

50¢, round to the even number of dollars.

DEFINITIONS AND INSTRUCTIONS FOR ACCOUNTS

SERVICES TO CHILDREN UNDER 36 MOS. OLD

Children under 36 months of age who are enrolled in the PCC are included in this account. If a child is continued in the program beyond his 36th month, he is to be included in Account Series 30 and no longer counted in this category.

11. Including baby sitting, child care, infant cognitive stimulation, individual or group activities in home or center. Includes diapers, play things, and cribs. Includes all services for the child himself except medical and dental services, or food.

12. Includes all Medical and Dental services, including diagnosis and treatment, nurse's services at the center, medications, supplies and insurance costs for the child. Where a health insurance policy is being paid by the PCC for the whole family, the insurance company can provide an annual figure which represents the infant's "share" of the premium.

13. Includes food, formulae, costs of cooks or nutritionists, and cooking equipment and utensils. Include all costs of food served to infants at Center.

19. This is the total for each column of costs of services for children under 36 months of age.

SERVICES TO PARENTS

This account covers all PCC services to the parents of children under 36 months of age, and to pregnant women enrolled in the program.

21. GENERAL PROGRAM SERVICES

Including homemaker service, referrals to legal, job placement or other services, employment counsel~~l~~ing, job development, recreation, housing assistance, and casework.

FORM F-1 (Continued)

22. HEALTH SERVICES

Including medical and dental examinations or treatment, nursing services, individual or group counseling and psychotherapy. Include Family Planning services or lectures.

24. CLASSES OR INSTRUCTION FOR PARENTS

Including academic, vocational, family-life education, consumer education, home management, child development, family planning, health care, etc.

23. NUTRITION AND FOOD

Include food provided to parents for whole family. Include classes, demonstrations and instruction in nutrition and cooking. Include meals, if any, served to parents.

29. Total of each column for services to parents.

SERVICES TO OTHER FAMILY MEMBERS

This includes all services and activities provided to other family members -- children over 36 months of age and other adults in the family who are not themselves parents of children under 3 years of age.

31. Includes all services and costs other than medical, dental, or psychological services which are listed under C 2. Does not include food or nutrition, if any. Includes recreational, tutoring or other services provided by PCC for these other family members.

32,33,34. Includes same types of costs as are included in 22, 23, and 24.

39. Total of each column for costs of services to other family members.

49. COMMUNITY DEVELOPMENT

Including community meetings, board or committee meetings, meetings with other agencies, community visitors, public education, and public meetings. Includes reimbursement of PAC members aside from transportation.

FORM F-1 (Continued)

59. ADMINISTRATION AND SUPPORTIVE SERVICES

Including Inservice training, staff meetings, supervisory conferences, writing reports, keeping records, traveling, time with visiting consultants, other "official" visitors. Includes space, utilities, maintenance and repair costs not assignable above for both staff and families.

TRANSPORTATION

All local and other travel costs, including mileage, equipment, driver's salaries, auto repairs and insurance, gasoline and oil, air and rail travel.

61. VISITING FAMILIES

Costs of staff visits to families. Estimate staff cost of travel time as well as mileage or other measure of transport expense. If mileage is reimbursed, include it under "other." If center supplies car and gasoline, etc., break it down between equipment and supplies.

62. TRANSPORTING FAMILIES OR CHILDREN

This includes costs of picking up children and parents to take them to the center, to a physician or to another service or agency. It includes the cost of reimbursing PAC members or other parents for travel to the PCC.

63. OTHER STAFF TRAVEL

Includes local and out of town travel to other agencies for meetings, to CAA or NSP offices, to PCC meetings away from the Center, and for PCC national or regional conferences. Includes convention travel, and value of staff time.

69. Total travel costs for each column.

Column 90 Add together those lines on this page whose numbers are enclosed in boxes. i.e. $\boxed{49}$, $\boxed{59}$, $\boxed{69}$

Underneath these, enter the sums of those lines from the preceeding page which are marked in the same way. i.e. $\boxed{19}$, $\boxed{29}$, & $\boxed{39}$

GRAND TOTALS

Line 91, is the sum of these figures, and equals all of the costs of each category of expense, both Federal and non-federal, except for Non-Recurring and Other expenditures.

FORM F-1 (Continued)

89. NON-RECURRING COSTS

This includes one-time-only expenses, such as remodeling or renovating a facility, putting in or repairing a heating system, and equipment which remains part of the building, such as a sink or water heater. The cost of program equipment should be amortized over 36 months, and included as equipment cost in columns 7 and 8. Do not count as equipment anything costing less than $100. Such purchases should be listed as supplies.

79. OTHER

Use this line only if there is a category of time and expense that clearly does not constitute service to families or children, or administration, or community relations or travel. If used, attach a detailed description of the account

INSTRUCTIONS FOR COLUMNS

General: Each category of expense is divided into separate columns for expenses made from Federal monies and for expenses or donations from local or other non-federal sources. The grand total of both should reflect total expenses, which may be different than total income for the quarter.

However, the total of donations other than equipment listed in the Quarterly Income Report will ordinarily be reflected in the total expenditures from non-federal sources.

Columns [1]&[2] STAFF SALARIES

The total amount of all staff salaries allocated to each account. This can be derived from your own time sheets, or by estimating the proportion of time each staff member devotes to activities that fall under various accounts, and allocating salary costs accordingly. These allocations should include fringe benefits, such as Social Security, health insurance, Workmen's Compensation, etc. This allocation should be done carefully, and where it is not clear, the staff member and his supervisor should be consulted. Fortunately most job assignments are sufficiently clear as to provide an objective basis for assignment. Remember to assign travel time to Account Series 60.

FORM F-1 (Continued)

Columns [3] & [4] CONTRACT AND CONSULTANT FEES

Included here are all services purchased from other agencies, companies or individuals. This may include medical insurance premiums, payments of physician's or dentist's fees, accounting fees, or tuition to a local trade school. It would include day care where this was purchased from another agency, laboratory test costs, and consultant fees to an outside training or research consultant.

Columns [5] & [6] All supplies, and equipment costing less than 100 dollars. Assignment of these expenses to accounts will usually be simple. Children's toys, clothes and cribs, clearly fall on line 11, while file folders and stationery fall on line 59. Where a given type of supply, such as mimeograph paper is used in all accounts, a sensible allocation of costs should be made.

Columns [7] & [8] Equipment includes all equipment costing over 100 dollars. Include here the rental cost of rented equipment. Do not include donated equipment, or equipment which becomes a permanent part of the building, such as a furnace. These should be charged to space costs. Amortize equipment over 36 months.

Columns [9] & [10] Space costs include rent, renovation cost, maintenance, utilities and repairs to the building. Since these can be translated into square-foot costs, allocations to various accounts should be reasonably clear-cut.

Columns [11] & [12] "Other" includes telephone, postage, and similar expenses which do not fall into the other columns.

Columns [13], [14], & [15] In this column are the totals for each account and category of account. The sum of the account totals in column [15] should equal the sum of columns in Line 91 plus any costs listed in 79 and 89.

FORM F-1 (Continued)

NATIONAL PARENT CHILD CENTERS STUDY

KIRSCHNER ASSOCIATES, INC.
11716 WEST PICO BOULEVARD
LOS ANGELES, CALIFORNIA 90064

DIRECTOR'S QUARTERLY PROGRAM ACCOUNTS REPORT

(See Instructions)

LOCATION OF CENTER (CITY,STATE)________________________________

PERIOD COVERED BY THIS REPORT________________________________

PART ONE

	VOLUME OF SERVICE ACTIVITY		
	1 NO. OF DIFFERENT PERSONS SERVED	2 NO. OF CONTACTS	3 NO. OF REFERRALS
SERVICES TO CHILDREN UNDER 36 MONTHS			
11. PROGRAM SERVICES			
12. HEALTH SERVICES			
13. NUTRITION AND FOOD			
19. TOTALS			
SERVICES TO PARENTS			
21. PROGRAM SERVICES			
22. HEALTH SERVICES			
23. NUTRITION AND FOOD			
24. CLASSES & INSTRUCTION			
25. MEETINGS			
29. TOTALS			
SERVICES TO OTHER FAMILY MEMBERS			
31. PROGRAM SERVICES			
32. HEALTH SERVICES			
33. NUTRITION AND FOOD			
34. CLASSES & INSTRUCTION			
39. TOTALS			
GRAND TOTALS			

ATTACH COPY OF MIS REPORT FOR THIS PERIOD

FORM F-1 (Continued)

NATIONAL PARENT CHILD CENTERS STUDY -- KIRSCHNER ASSOCIATES, INC., 11716 WEST PICO BOULEVARD, LOS ANGELES, CALIFORNIA 90064

PART TWO: PROGRAM COSTS PCC DIRECTORS QUARTERLY PROGRAM ACCOUNTS REPORT

CENTER (CITY,STATE)____________________ PERIOD COVERED BY THIS REPORT__________

Account No.	Component Service	1 Staff Salaries	2	3 Contracts and Consultant Fees	4	5 Supplies and Materials	6	7 Equipment	8	9 Space and Utilities	10	11 Other (Describe Over)	12	13 Totals	14	15 Grand Total
		Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Each Row
	SERVICES TO CHILDREN UNDER 36 MONTHS OLD															
11	Program Services															
12	Health Services															
13	Nutrition and Food															
19	Totals															
	SERVICES TO PARENTS															
21	Program Services															
22	Health Services															
23	Nutrition and Food															
24	Classes and Instruction															
25	Meetings															
29	Totals															
	SERVICES TO OTHER FAMILY MEMBERS															
31	Program Services															
32	Health Services															
33	Nutrition and Food															
34	Classes and Instruction															
39	Totals															
	COLUMN TOTALS THIS PAGE															

FORM F-1 (Continued)

Account No.	Component Service	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		Staff	Salaries	Contracts and Consultant Fees		Supplies and Materials		Equipment		Space and Utilities		Other (Describe Over)		Totals		Grand Total
		Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local	Each Row
49	COMMUNITY DEVELOPMENT															
59	ADMINISTRATIVE & SUPPORTIVE SERVICES (Not included in 11-49 above)															
	TRAVEL & TRANSPORTATION															
61	Visiting Families															
62	Transporting Families															
63	Other Staff Travel															
69	Total Travel															
90	COLUMN TOTALS															
	TRANSFER COLUMN TOTALS FROM FIRST PAGE															
91	GRAND TOTALS															
89	NON-RECURRING COSTS: i.e. Renovation															
79	OTHER (Describe on Separate Sheet)															

FORM F-2

NATIONAL PARENT CHILD CENTERS STUDY

KIRSCHNER ASSOC., INC. - 11716 W. PICO, LOS ANGELES, CALIF. 90064

QUARTERLY INCOME REPORT

Center (City, State) ____________________

Period Covered By This Report ____________________

	THIS QUARTER	YEAR TO DATE
CASH INCOME:		
Federal Grant Received	☐	☐
Other Cash Received	______	______
Total Cash Received	______	______
CASH VALUE OF DONATIONS		
Office Equipment	______	______
Program Equipment	______	______
Program Supplies	______	______
Office Space	______	______
Program Space	______	______
Professional Time *	______	______
Non-Professional Time *	______	______
Other (describe on reverse side of this sheet)	______	______
Total Donations	______	______
Total Income	☐	☐
Federal Cash Received / Total Income =	______%	______%

* Use the hourly wage or usual fee of the professional to compute the value of his donated time. Note that he cannot donate the difference between what you pay him and his usual fee, however. Only fully donated time can be counted.

In the case of non-professional tasks, count these donations as worth $1.65 per hour, regardless of the person's usual income. For example, if a physician volunteers to run the mimeograph machine, that time is worth $1.65 per hour. If he examines children, then his time is worth his usual fee.

FORM F-3

NATIONAL POISON CONTROL CENTERS STUDY
KIRSCHNER ASSOCIATES, INC.
[illegible] WEST PICO BOULEVARD
LOS ANGELES, CALIFORNIA 90064

STAFF TIME ACTIVITIES SUMMARY

Location
of Center______________________________________ Time Period______________

THIS FORM IS TO BE COMPLETED BY THE PROJECT DIRECTOR

Based upon your own time records and logs, list the total number of hours spent by your staff in each of the categories listed below for the last three months. Do not include time spent by other agencies. Do include your own staff and volunteers.

MAN-HOURS OF STAFF TIME

PLEASE FILL IN THE BLANKS AND DO THE INDICATED ARITHMETIC

I. STAFF PAID BY PCC

(1) TOTAL NUMBER OF WORKING DAYS IN THIS QUARTER = ______________

(2) MULTIPLY (1) X 8 HOURS PER DAY ______________ x 8

(3) = TOTAL NUMBER OF WORKING HOURS THIS QUARTER = ______________

(4) NUMBER OF FULL TIME STAFF = ______________

(5) MULTIPLY (3) X (4) = ______________

(6) ENTER TOTAL NUMBER OF HOURS WORKED BY ALL PART-TIME STAFF THIS QUARTER ______________

(7) ADD (5) TO (6) = ______________

(8) ENTER TOTAL HOURS OF OVERTIME WORKED THIS QUARTER = ______________

(9) ADD (7) TO (8) = ______________

(10) ENTER TOTAL HOURS OF SICK LEAVE AND VACATION TIME = ______________

(11) SUBTRACT (10) FROM (9) = ______________
TOTAL MAN-HOURS PAID BY PCC

(12) ENTER TOTAL MAN-HOURS OF STAFF TIME PAID BY OTHER AGENCIES ______________

(13) ENTER TOTAL HOURS VOLUNTEERED THIS QUARTER = ______________

(14) ADD (11) + (12) + (13) = ______________
TOTAL MAN-HOURS EXPENDED IN PCC PROGRAM THIS QUARTER

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